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AUTHOR Stegman, Carolyn Beitzel
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ABSTRACT

Patient care in a hospital setting is directly related to the professional information and knowledge exchange between physicians and nurses concerning patients in their own care. This exchange, while informal, is considered a teaching-learning transaction. In recent years, as gender ratios in medicine have changed, a new transaction has arisen between female physicians and female nurses, and a study of the social and environmental factors which influence and impact these women is presented. Data was collected chiefly by means of open-ended nonstructured interviews with 50 members of the two groups under study working in a range of institutions located in the eastern half of the United States. Chapter topics include: female physicians' and female nurses' perceptions of the teaching-learning transaction strengths between each other as women; how respondents felt the teaching-learning transaction between women enhanced patient care; socialization and bonding; the issue of sexuality; the emergence and analysis of barriers; and the effect of negative incidents. The study indicates that the teaching-learning transaction between women is different and largely positive (with more teaching and learning), though in some cases, this positive interaction contains an undercurrent of manipulation. Six major recommendations focus on designing educational curricula to be shared with women in medicine and nursing through their professional literature and associations and in workshops. An appendix includes sample interview questions, and 70 references are provided. (SM)

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THE EFFECTS OF SOCIAL AND ENVIRONMENTAL FACTORS ON INFORMAL TEACHING-LEARNING TRANSACTIONS BETWEEN FEMALE NURSES AND FEMALE PHYSICIANS

by

Carolyn Beitzel Stegman

P.O. Box 114
Princess Anne, Maryland 21853

A Major Applied Research Project presented in partial fulfillment of the requirements for the degree of Doctor of Education

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C.B.S.

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Abstract of a Major Applied Research Project Presented to
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THE EFFECTS OF SOCIAL AND ENVIRONMENTAL FACTORS ON INFORMAL TEACHING-LEARNING TRANSACTIONS BETWEEN FEMALE NURSES AND FEMALE PHYSICIANS

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Patient care in a hospital setting is directly related to the professional information and knowledge exchange between physicians and nurses concerning patients in their care. This exchange, while informal, is considered a teaching-learning transaction. Within the communicative teaching and learning framework are the processes of assessment, planning, problem-solving, implementation, and evaluation. The quality and quantity of these transactions in the hospital milieu are vital as a continuing educational responsibility because there is immediate contribution toward optimal patient well-being.

Until recently, this doctor-nurse transaction was simultaneously and almost exclusively a male-female transaction, further characterized by stringent role and gender expectations and stereotyping. The teaching-learning process as it influenced patient care was more one-way than mutual, thus contributing to adversarial conditions.

Today women seek a broader spectrum of opportunities and one profession, medicine, has seen drastic gender ratio changes. This brings to light an emerging new transaction--the one between female

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physician and female nurse. Daily, in hospital settings, these doctors and nurses exchange patient information, patient progress, and plan future care requirements. The purpose of this Major Applied Research Project was to study this teaching-learning transaction from a professional and gender perspective and in regard to the social and environmental factors which influence and impact these women.

This research was qualitative and exploratory, and utilized the methodologies found in naturalistic inquiry and grounded theory, where concepts are generated from data. Specifically these included the use of the open-ended nonstructured interview process. Taped interviews from 50 women in nursing and medicine supplied the data that served as the basis for discovering an understanding of the dynamic perspectives affecting this transaction.

Analysis of data was ongoing as each interview was completed so that emerging conceptual categories could be coded and followed in subsequent interviews. Formation of hypotheses and variables likewise came from the data and were systematically analyzed in relation to the data during the course of this research.

According to those interviewed, the teaching-learning transaction was definitely perceived as different between female M.D.s and nurses than between male M.D.s and nurses. This was first seen in interviewee discussions of approachability, climate setting, rewards, amount of teaching, and in the willingness of the female M.D. to assist in the care of the patient. They felt that in this atmosphere doors were opened to enhance teaching and learning, hence each profession's motivation to maximize its potential. Furthermore, the interpersonal quality within the transaction was transferred to the patient as

evidenced in interviewee ideas of appropriate psychosocial support and discharge planning.

Exploration into the reasoning for this progression in informal teaching and learning prompted introspection about the socialization of women. The women interviewed reiterated that various feminine characteristics, such as nurturance, were positive attributes in the application to health care. These same characteristics produced a bonding between women, which was further intensified as they reflected on past prejudices evolving from traditional attitudes on the prescribed place of women in our society.

Inherent in social and environmental linkage among women were potential barriers. This was vividly seen as interviewees analyzed the gender expectations for other women. Nurses expected female physicians to be caring and sensitive, treat nurses as equals, respect them, be clinically competent, not present themselves as a traditional authoritarian physician, and not flaunt their status or wealth. Female M.D.s expected nurses to respect their role difference and respect them, not take advantage of them, not cater to male M.D.s at their expense, be capable, and be nurturing. Incompetence and a lack of nurturance were tolerated by neither profession because that woman "represented us." The results of these unfulfilled expectations were barriers, and the result of barriers was a reduced effectiveness of the teaching-learning transaction.

There were four perceived reasons that emerged which interviewees felt triggered conflict among women enough to interfere with the teaching-learning transaction. Included in these are first, the ambivalence of and often negative reaction to women as authority

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figures. Both nurses and female M.D.s believed that women are less intimidated by other women. While this was by-and-large viewed as a positive change from traditional authoritative control, there was negativism if it implied a lack of respect or competition towards other women. Second were the disparities between medicine and nursing regarding status, economics, educational levels, and power. Hostilities between medicine and nursing were exacerbated as women viewed these differences within their own gender. Third was the health care system itself, which often created varying degrees of self-esteem and job satisfaction between the two professions. Fourth was the perceived negative aspects of feminine socialization, such as passivity, which prompted feelings of inadequacies or unpreparedness in the professional world.

In summary, the teaching-learning transaction between women was different and this difference was largely a positive one. There was more teaching and learning, and so much so that many felt patient care benefitted significantly. Yet this positive interaction, in some cases, contained an undercurrent of manipulation, and, while this did not necessarily alter the quality of the teaching-learning transaction all the time, the potential was there to do so. Therefore, initial desired colleagueship between these women because of their gender was sometimes replaced by an adversarial competitiveness, also because of their gender.

The major recommendations of this endeavor concentrate on designing educational curricula which can be shared with women in medicine and nursing through their professional literary sources and associations, and in workshops. These data will contribute to increased understanding

of informal teaching-learning transactions and provide guidelines for ongoing positive colleagueship. Nurses and physicians will benefit from this research by increasing each other's professional motivations and capacities to enhance the delivery of health care. The ultimate benefit will be to the patient.

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CHAPTER 1

INTRODUCTION

BACKGROUND AND SIGNIFICANCE

Professional development in a dynamic, technological society is exceedingly important. In two professions, medicine and nursing, it is more than important; it is critical. With the almost daily influx of new materials, medications, and procedures, lifelong learning and continued education are not considered luxuries; they are essential to the safety and the welfare of patients.

There are two general avenues of professional development for doctors and nurses. One is formal continuing professional education, which is now mandated by many states for both professions. The other is informal teaching-learning transactions that occur naturally during the course of daily activities.

The focus of this Major Applied Research Project (M.A.R.P.) was on the informal teaching-learning transactions as they occur within a hospital setting and as they relate to the care of patients. An informal teaching-learning transaction is communication between physicians and nurses where the major purpose is to teach and learn. This includes a flow of information and problem solving between two autonomous yet interrelated professions. These transactions occur many

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times daily, often at a patient's bedside and, depending on the quality and scope, can actually affect the outcome of a patient's illness.

The effective communication between M.D. and nurse is the link toward a meaningful teaching-learning process. Rogers (1962) defined communication as a process in which individuals create and share information with one another in order to reach mutual understanding. Havelock (1971) defines communication as, "Who says what to whom, by what channels, and to what effect."

Informal teaching-learning transactions have many advantages. First, nurses and doctors do not have to leave the work situation to learn. Second, learning occurs at the "teachable" moment when the problem is identified. Third, what is learned can be used immediately by both professions to benefit the patient. Fourth, learning has a practical application. Fifth, results can be seen as soon as they occur.

Nursing care is delivered on a 24 hour basis. The physician, while potentially available during this period, usually is in contact with the patient only once, or proportionally to the acuteness of a patient's illness. The ideal two-way communication process between nurse and M.D. is either face-to-face or by phone. When this occurs the nurse reports the condition of the patient, the events since the last doctor visit, various nursing measures employed during this course, and possible recommendations. The doctor, utilizing this information, prescribes new orders and plots medical progress, and then relates this back to the nurse. Queries, explanations, verifications, and quantifications all may occur in this process. This cycle continues until the patient is discharged from the hospital.

This cycle represents informal teaching-learning transactions between doctor and nurse, consisting of knowledge dissemination, mutual problem solving, and planning. One presents information, the other assimilates this in relation to her role, and reacts to produce a plan and prescription. Communication between the two is purposeful and oriented toward learning and problem solving. Therefore, the more information presented in the transaction, the more criteria one has on which to base a decision and plan of action which can contribute to patient well-being.

Teaching-learning transactions can be conceived in many ways. One useful conceptual model derives from communication theory in which knowledge, skills, or attitudes are transferred from one source of expertise to a receiver within an environment and includes factors which facilitate and impede communication. Since a valuable source of expertise for nurses' and doctors' non-formal learning is each other, it becomes important to understand the social and environmental factors which promote or hinder teaching-learning transactions between physicians and nurses.

The traditional male doctor-nurse relationship had its share of adversity. While many nurses and male physicians feel they have warm, collegial relationships with each other, genuine problems exist between the two professions. Hoekelman (1975) noted class stratification, educational differences, economic disparities, and misunderstanding of each other's professional role as some of the major causes of conflict. Coleman (1984) added poor communication, antiquated administrative policies, sexism, struggles over money and turf, and the changing role of nurses.

Recently many authors from both professions have studied the factors which have contributed to this primarily autocratic interprofessional relationship. Maraldo (in Coleman, 1984) believes that the root of the problem is the male-female relationship. She goes as far as to suggest that there are strong analogies between the husband's, or even the father's role in the home and the physician's role in the hospital.

Traditional nursing education has supported this autocratic relationship. Duff (1968) found curricula which valued obedience to orders and respect for authority. Ashley in her book, Hospitals, Paternalism, and the Role of the Nurse (1976, p.77), described the historical suppression of nurses by physicians. She included one nursing commencement address in 1908 by a physician who said

> If a little knowledge is a dangerous thing in most avenues of employment, in nursing it is more than dangerous--it is fatal. I believe that a superficial knowledge of anatomy and physiology, together with a thorough acquaintance with hygiene, will answer every purpose.

The M.D. is educated to heal through diagnosis and treatment. The nurse is educated to care for patients during this process and to aid it. But to believe the concept that physicians cure while nurses care is erroneous, because caring fosters healing, hence curing. Likewise, healing needs caring. In other words, the two professions are not mutually exclusive. There are overlaps and mergings.

In spite of this, physicians and nurses often blame each other for not understanding the others' job, hence leading to barriers in teaching-learning transactions. Ambrose (1977) asked nurses and

physicians to rank the importance of nurse activities. The physicians ranked "following his orders" as a nurse's first priority, while nurses ranked "physical assessment of patient needs" as number one. Lee (1979), in surveying physicians, found that 75 percent of all M.D.s view nurses as their assistants. Many M.D.s likewise, feel that nurses are shift-oriented and leave at precisely the end of shift, regardless of patient needs. Nurses, on the other hand, say physicians treat them like "handmaidens." And so the list of discrepancies goes on.

Duff and Hollinghead (in Muff, 1982, p.224) described the male doctor-nurse team in a university medical center as follows:

> Physicians and nurses did not work closely together except in surgery and other selected procedures. On patient care divisions, they did not communicate with one another as much as they did among themselves. The chief link between physicians and nurses was the doctor's order book--a one-way communication.

"Abusive physicians" and underutilization of nurse expertise have often surfaced as reasons for many nurses' departure from nursing and, from a nursing standpoint, the cause of so much negative transaction. Muff (1982) said nursing scholars attribute this to inequality of the two professions before the law, in the clinical setting, and in the public eye. The medical profession is accorded privileges and positive images not given to the nursing profession. Furthermore, there are deficient communication patterns between doctors and nurses, with most of that taking place through the "Doctor's Order Book." This all leads to, as Muff (1982) described, a narcissistic fit between medicine and nursing. One is undervalued, the other overvalued.

The women's movement and increased education have had effects on the nursing profession. Nurses are becoming increasingly vocal and are fighting for more power and autonomy in the health care system. More and more, as Muff (1982) described, they refuse to be "the handmaiden" for the physician and are seeking more active participation in patient care planning and implementation.

The influence of women's movement for rights and choices has afforded vast opportunities for many women and today the career doors keep opening wider. Over the last couple of decades, women have entered and succeeded in traditionally male-dominated career arenas. Less and less are women being tracked by parents and teachers into the traditional pink-collar professions of secretarial work, nursing, or teaching: all heretofore considered stopgaps prior to the ultimate profession of wife and motherhood.

One of the bastions of almost total male dominance has been the medical profession. However, approximately 32 percent of entering medical students in 1982-83 were women (JAMA, 1982). That is more than three times the percentage of women entering in 1969. In 1982, 3,991 women became medical doctors compared to 11,994 men. In 1983, 26.7 percent of all medical school graduates were women.

One traditionally female profession, nursing, cannot say the same about sex enrollment changes. Muff (1982) described nursing, with its stereotypic image of caring, nurturing, and subservience, as almost a caricature of womanhood and, as such, has long been regarded as a "natural" job for women or an extension of women's work. Consequently, nurses are still predominantly female. In 1977, only 27,301 of the nation's over one million nurses were male (NLN, 1979). While the

number of males in nursing has increased by 86.7 percent since 1972, their relative proportion in the population show only slight gains. In 1972, males comprised 1.3 percent of the nurse population, and in 1981, 5.6 percent.

The trend towards significant increases of women in the medical profession presents an interesting new development. Nurses (henceforth regarded as females in the context of this research) and female doctors are continually coming into contact with one another as members of the health profession. How will this affect the informal teaching-learning transactions? Will similar gender play a significant role in the barriers or facilitation of this communicative process? Coleman (1984) talked with nurses and female physicians. Both felt that while some problems exist, women seem to have more camaraderie and better working interactions than male physicians and nurses. But the social and environmental problems are difficult ones. One female physician noted that while they are both females, one has "made it" and one has not. Another female physician said that many times a woman becomes a physician to forget that powerless, subservient, classical female role in which she has always been. A nurse found that while many nurses admire the female physician for having achieved a full potential, there is also envy because many nurses feel they never had the opportunity. On the other hand, one female physician said that female physicians have a great deal more sympathy, empathy, and a better rapport with nurses than male physicians, influencing more quality transactions.

To further understand teaching-learning transactions, in this context, the following case study scenarios are offered:

Dr. Jane Doe, an orthopedic surgeon, came to the nursing unit to see patient Alice Smith. Smith is a 79 year old widowed female who had fallen two weeks previously and fractured her hip. She had surgery to repair her hip and is now walking with the assistance of a walker. She has progressed as expected since her operation, has had no complications, and will be ready for discharge in about two days.

Dr. Doe approaches nurse Ann Jones who is taking care of Smith. Jones confirms that physically the patient is progressing nicely. However, Jones has become concerned about the patient's emotional status since Dr. Doe's last visit. Jones explains to Doe that since imminent discharge was proposed to Smith, she has been very nervous. Doe is interested in this because she knows Smith's total well-being rests on her ability to safely function once out of the hospital. When Jones first noticed this, she talked with Smith. She found out that Smith, indeed, was scared. She was afraid of negotiating a flight of stairs with a walker and afraid that she wouldn't be able to cook and clean for herself. She is in fact so anxious that she was unable to sleep the night before, and her appetite has decreased. If this continues, her physical health is in jeopardy.

Together Jones and Dr. Doe are presented with multiple problems. Their dialogue now progresses to problem solving with each contributing their educational expertise to this situation. Jones asks if a sleeping pill might not be appropriate to help Smith over the next couple of nights. Doe rejects this, but carefully explains her rationale to Jones.

Both Jones and Doe consider extending Smith's hospitalization until the patient feels more comfortable. They decide this is a possibility,

but should be a last resort because further hospitalization is expensive and will only delay what Smith must still face. Both consider nursing home placement as a short term remedy until Smith no longer needs a walker.

Dr. Doe inquires about a nurse's aide in the home. Jones queries since this is expensive and she knows Smith is living on a fixed income. Then Jones presents to Doe the other options available by commmunity organizations set up to aid the elderly. She explains to Doe that there is a federally funded program to bring hot meals into the homes of the elderly. This would solve the cooking problem. Doe asks for Jones's opinion of this option.

The transaction continues between Doe and Jones until tentative plans are reached. These are further discussed in the presence of the patient, who will ultimately benefit from this. Smith is more relaxed after they all talk and, with these assurances, begins looking forward with confidence to her hospital discharge.

In this teaching-learning transaction, which could have reasonably taken place in ten minutes, standing in the nurse's station of a busy unit, both Jones and Dr. Doe have been teachers and learners. This quality transaction has included issues in physiology, pharmocology, rehabilitation, psychology, social services and the problems of the elderly. The dialogue has been informal, yet there has been a large profile of information exchange and integration. Unless there is an unexpected emergency with this patient, Doe and Jones will not talk again for 24 hours. At this point, they will engage in another teaching-learning transaction, the goal of which will be bringing Smith even closer to emotional and physical well-being.

If we consider the same case under entirely different circumstances, one can visualize how an altered teaching-learning transaction can affect the outcome for the patient:

Dr. Doe is rushed. She has an office full of patients and is now almost an hour late. Nurse Jones is likewise busy; one of her patients is dying of cancer, and this has been an emotionally tense situation for Jones.

Doe approaches Jones on the status of Smith. Jones reports that Smith did not sleep last night and is progressively depressed about going home. Doe is writing progress notes on another patient while Jones is talking. This annoys Jones. Then Jones receives a phone call from the family of the terminal patient. This annoys Doe as she hoped Jones could talk on the phone later. As Jones walks away to answer the phone, she hurriedly asks Doe to write an order for a sleeping pill. Doe, now totally rushed, does and leaves. When Jones gets off the phone, Doe is gone and she hasn't talked to her completely about Mrs. Smith's apparent depression. She furthermore assumes that Doe isn't really interested.

Mrs. Smith, of course, remains depressed, but gets a sleeping pill that night so she can sleep. The effects of the sleeping pill cause her to become slightly confused. She is discharged to her home two days later, and is crying as she leaves the hospital.

The effects of time have dramatically altered this transaction. In fact, this teaching-learning transaction was severely compromised. There was neither teaching nor learning in this transaction. Furthermore, negative nonverbal messages were passed between Jones and Doe, and Smith ultimately suffered. She left the hospital with a

repaired hip, but fearful about the future and with no professional intervention to alleviate her anxieties. The potential for both Jones and Doe to alter this course was never realized. And, Jones and Doe did not benefit each other with their respective professional expertise.

A third possible scenario for this same case study presents another example of a missed opportunity to expand the teaching-learning transaction:

Dr. Doe is a successful orthopedic surgeon and has had to work very hard to achieve her position of respect and competence. This success has had its financial and status rewards. Dr. Doe will receive up to $4,000 for repairing and caring for Mrs. Smith's fractured hip. On the other hand, nurse Jones will not make that much money in three months of full time work.

Dr. Doe is very formal in her approach to the nurses, insisting on being called Dr. Doe. She dresses expensively and wears half glasses. Jones presents Mrs. Smith's case and potential depression to Doe. When Jones suggests the sleeping pill, Doe quickly rejects it and adds that this request was inappropriate. Now Jones is intimidated and feels uncomfortable discussing Smith's case further. The dialogue regresses to Doe's asking questions and Jones giving short answers, but not volunteering any information. Doe writes an order in the chart to call Social Services and have them decide how Mrs. Smith is going to be taken care of after she goes home. She is not interested in asking for Jones' opinion. She communicates her orders by having Jones read the chart. As Doe leaves the unit, an M.D. colleague approaches her and calls her by her first name. They exchange informal conversation. She is distinctly more casual than in her interaction with Jones. When Doe is

gone, Jones makes an off color joke to another nurse about Doe's tacky clothes. That night Doe is called at 11:30 p.m. to be told that Mrs. Smith can't sleep again. She again rejects the request for a sleeping pill and slams the phone down. The next day Jones takes a break when she sees Doe coming on to the unit.

The above transaction is ultimately affected by social factors, such as wealth and power, which translate to heterophilous (dichotomous) differences between this doctor and nurse. These ultimately marred this specific teaching-learning transaction. Moreover, in this case, future teaching-learning transactions not only suffered, they became non-existent.

There are obviously numerous gradations to the potential capacity or lack of capacity of teaching-learning transactions, ranging in quality and quantity and affected by many variables. These influence how much will be shared between doctors and nurses, and these transactions directly and indirectly can have profound ramifications in the outcome of patient care.

In the scenarios, the environmental factors included time, the effects of a busy nursing unit, and the constant pressures on both nurse and doctor. The social factors included the status and economic differences between the nurse and doctor, the use of power, and the role perceptions each had towards the other profession. Together these factors affected the teaching-learning transaction.

Without teaching-learning transactions, doctors and nurses basically work alone. This is not necessarily negative in all terms of patient care, but rarely can one say it is positive. First, lost is the ability for each of these professionals to communicate the knowledge

base they are applying to any specific patient. Second, this lack of communication may cause the other to make a decision without having all information at hand. Third, neither may understand why the other is doing something. This, of course, may lead to further misunderstanding. Fourth, the job of taking care of the patient becomes more rote or task oriented, because the less one is involved in a decision-making process, the less one becomes involved in a motivated application of this process. Fifth, an opportunity to teach and learn is missed.

When physicians and nurses work together, the transactions introduce the opportunity to share substantially. This sharing contributes to a mutual scientific processing and assimilation of data. This process begins by identification of problems and ends with evaluation. When this breaks down, one or both may lose the benefit. The patient always does.

In the first scenario, Dr. Doe, without the teaching-learning transaction between herself and Jones, may have ordered a nursing aid for Mrs. Smith. Smith, unable to afford it, might have discharged the aid prematurely. Likewise, Jones was taught something about the side effects of ordering sleeping pills for elderly hospitalized patients. The transaction also increased their motivation to talk again. The positive process created became cyclical, and the participants were motivated to apply their professional strengths to the positive outcome for Mrs. Smith. In the process, their own knowledge base increased, hopefully to be applied in future patient care problems.

The type of knowledge shared can be different for the respective roles of physicians and nurses. Physicians, with their years of

scholarly educational background, can share a substantial scientific basis for medical care decisions. The more the nurse is exposed to this, the more she is able to assist the doctors in evaluating their medically prescribed regime, and be constantly alert to significant clinical changes in the patient.

The nurse, on the other hand, has the advantage of a long term relationship with the patient, and most nurses have an educational background strong in discharge planning and patient education. She is therefore in a unique position to relay information to (i.e. teach) the physician things which ultimately impact his/her prescription. This strength of nursing enhances its capacity to give information to doctors which they are not (because of time factors) able to observe or solicit.

So, in working together, each profession augments the other and in many ways brings out the ideal capacities they have to offer. When they work separately or compromise, the teaching-learning transaction becomes a one-sided communication process, and their potentials lessen accordingly. Furthermore, if because of social and environmental factors, teaching-learning transactions occur minimally or not at all, the stage is set for reduced quality of patient care or at worst, faulty decisions and even mistakes. However, when these two professions join their strengths, the patient will receive benefits from this union. Likewise, the doctor and nurse teach and learn from each other.

Continued exploration of the reciprocal relationship of informal teaching, learning, and subsequent behavior between female doctors and nurses is vital to the ongoing professional development of both professions. As previously stated, the traditional doctor-nurse transaction, because of various social and environmental factors, one of

which was gender, has not been mutual. Because the M.D. and nurse belonged to distinct reference groups having asymmetrical power, most teaching-learning transactions have been analogous to a pedagogical model. The female physician, however, has two reference groups--female and physician. The extent of influence this has on teaching, learning, and communication was assessed. Therefore the purpose of this major applied research project was to study the informal teaching-learning transactions between female physicians and female nurses, and assess the effect of social and environmental factors.

Statement of the Problem

Informal teaching-learning transactions are a vital link in patient care for physicians and nurses. Heretofore, various social and environmental factors, not the least of which were the gender differences depicting the two professions, have impeded the quality and the quantity of these transactions. But the traditional male doctor-female nurse ratio is changing. Increasingly nurses are working more with women physicians and all these women have been in some way affected by the emerging and diverse roles of women in our society.

At this time there is only cursory and anecdotal documentation of the barriers and facilitation of teaching-learning transactions between female physicians and nurses. Of the numerous articles which have addressed the physician-nurse interaction, all specify the physician as being male. With women now accounting for more than 25 percent of all physicians, the physician-nurse teaching-learning transaction needed to be assessed by this new standard.

The effects of social and environmental factors on informal teaching-learning transactions between female nurses and female physicians were not known and were therefore the problems which this study addressed. Information obtained from preliminary research suggested a desire for, and subsequent contributions to, more collegial transactions than have heretofore depicted the male physician-female nurse transactions. But problems did exist, and when they did, those involved felt that the teaching-learning transactions and patient care were compromised. Consequent collection and analysis of data which enhanced or impeded this process will hopefully go far toward contributing to a continued, mutually fulfilling transaction between women in these two professions.

Useful Conceptual Models for Understanding Teaching-Learning Transactions

While making hospital patient rounds, a female physician entered a room where a nurse was making an occupied bed for a patient. Upon seeing the physician, the nurse asked her to help tuck in the sheets on one side of the bed. The physician acknowledged and did it, later remarking that, while she was not insulted, she knew a nurse would have never asked a male physician to do the same thing. Leichter's (1978) concept of mediation applies here. She described mediation as the ongoing, moment-to-moment process of interpretation of events, and the filtering of educational influences, some of which are at the margins of awareness, which create meaning in experiences. Furthermore, she said that these educational experiences, minor as they seem, have a

cumulative effect which cannot be ignored. In relating back to the anecdote, the nurse asked and the female physician did, albeit with a later reaction. (The nurse's reaction is unknown.) This is a seemingly small experience, but with possible significant future ramifications, at least between these two individuals and in regard to the potential cooperative linkage between their two roles. Hence, while this anecdote does not describe a teaching-learning transaction, it has importance as a barrier or facilitator of future teaching and learning. If, for example, the physician had refused, barriers may have been set up impeding future transactions.

Leichter's model of mediation will serve as one of the conceptual bases in looking at the social and environmental factors influencing teaching-learning transactions. She describes education as not only deliberate but also as a process that occurs often, as stated previously, at the margins of awareness. Lifelong learning takes place in a variety of settings and ways, and this needs to be understood as it takes place in each of these settings.

Leichter (1978, p.609) also outlined several key elements of relationships which, when examined in the light of this investigation, can enhance the knowledge base of teaching-learning transactions between female physicians and nurses. The first of these elements asks the question, "Who teaches and learns from whom?" This question seeks to look at who participates as teachers and learners. To further describe the social composition of teachers and learners with respect to educational diversities, socio-economic differences, and age, Leichter used the term "co-presence." She viewed this as an important dimension

in looking at the processes of education, an end result of teaching-learning transactions.

Another element important in this investigation will be that of evaluation, of which Leichter noted two aspects. First are the procedures for evaluation. These may range from formal examination, to informal comments of approval for something learned well, to no comment at all. Second is the distinction made between the acquisition of knowledge and the acquisition of credentials.

The organization of space and its relationship to learning is a third element in Leichter's conceptual model. In the informal in-hospital teaching-learning transactions, this is a key consideration. As mentioned previously, a physician-nurse transaction often takes place at a patient's bedside, while standing in a busy nurse's station, or on the phone. Spatial organization influences the character of transactions and is therefore a dimension worthy of consideration.

The organization of time is the next element and is of clear educational significance. Important questions to consider in this area are the length of transactions, the time of day or week (since hospitals are open 24 hours per day and 365 days a year), the lack of scheduling of transactions, the flow or interruption of activities, or the amount of time each party feels is sufficient in the transaction.

Finally Leichter's (1978, p.619) element of pedagogic and educative styles asks, "Where the initiative for education lies and in what ways the reaction of the learner or teacher influences the actions of the other." Also inherent here are the kinds of feedback that take place between teacher and learner. This can be very different between

different individuals. Another dimension of educative style concerns the extent to which the learner's experience is active or passive.

Doctors and nurses disseminate knowledge to one another so that they may do their work. In this learning process the positiveness or negativeness of their behaviors toward each other is affected by patterns of communication. Havelock (1971) presented a conceptual framework for evaluating communication which serves as another conceptual model in this project. He called several of his themes "general factors" in knowledge dissemination and utilization. They are linkage, structure, openness, capacity, reward, and proximity.

Linkage is the degree of interpersonal or intergroup connection and the extent to which mutual communicative relations exist among two or more parties. The more linkages there are and the stronger they are the more effective will be the day-to-day contact and exchange of information, hence the greater the mutual utilization of knowledge and participation in decision-making processes.

Structure refers to the division of labor and coordination of efforts between people and between groups. Here one may look at the way knowledge is transmitted, especially in the sense of a horizontal or vertical pattern of communication.

Openness is the readiness to give and receive new information, the willingness to help, and the willingness to listen.

Capacity ties together the interrelated variables of wealth, status, education, intelligence, and sophistication.

Reward is the recognition given by colleagues and the resultant satisfaction. Rewarding encounters with new knowledge lead to

self-fulfilling prophesies that future encounters will also be rewarding.

Proximity refers to both a geographical and psychological handiness of resources. This is premised on the thought that anything which is accessible is more likely to be used. Proximity also makes linkage more possible.

Using the conceptual framework of linkage, structure, openness, capacity, reward, and proximity, one can now look at most informal teaching-learning transactions from two main viewpoints: First is barriers, and second is facilitation. Furthermore, both of these may be looked at from an interpersonal and intergroup level, although the major portion of this research was at the intergroup level.

In Everett Roger's book Diffusion of Innovation (1983), he described the concepts of homophily and heterophily. Homophily is the degree to which pairs of individuals who interact are similar in certain attributes, such as beliefs, social status, and educational level. Heterophily is defined as the degree to which pairs of individuals who interact are different in these same certain attributes.

Rogers believes that more effective communication occurs when two individuals are homophilous. The exception is when heterophilous individuals have a high degree of empathy towards each other, in which case, these individuals are really homophilous. The converse of this communicative framework is that effective communication leads to greater homophily.

In applying this concept to physicians and nurses, one sees many heterophilous elements: that of education differences, social status, economic status, and especially in the past, sex differences. These

disparities, as Rogers described, lead to problems in communication which then affect quality teaching-learning transactions. The female physician however, in one significant area, that of sex, is not heterophilous to the nurse. Using this element, one can explore the transactions between these women and describe the influence of gender similarity.

Another conceptual model which Rogers (1983) described and is useful in this endeavor is Individual-Blame versus System-Blame. Individual-Blame is the tendency to hold an individual responsible for his or her problems, rather than the system of which the individual is a part. System-Blame is the opposite tendency to hold a system responsible for the problems of individual members of the system. Therefore a particular problem or barrier may be of an individual nature, but in many cases the social aspects of that problem or barrier lie in the system or society of which the individual is a part. Since this study focuses on women and includes the social and environmental factors which have influenced the collective development and growth of women, one needs to be aware of the elements of Individual versus. System Blame. This same concept may likewise be applied as a concept of facilitation as well as barriers.

A conceptual model, which formed the groundwork for this project's methodological approach, was a process of studying qualitative social research known as grounded theory. It was defined by Glaser and Strauss (1967) as theory discovered from data which were systematically obtained and analyzed. Grounded theory focuses on social interaction and therefore relies heavily on data from interviews and observation. A main difference of grounded theory from quantitative methods is the

discovery of theory from the data, not testing of a theory empirically. The theory comes from data on structural conditions, consequences, deviances, norms, processes, patterns, and systems.

Glaser and Strauss used their grounded theory concept in a now classic book, Awareness of Dying (1966). This study began with no preconceived hypotheses or variables.. Instead, observation and interviews were the basis of study and comparison among groups. Initially they focused on an awareness context which is what interactants in a situation know about each other and the influence of this on social interaction. In other words, what interacting persons know of the situation, along with their recognition of the other's awareness.

From this, Glaser and Strauss began their research, and out of it arose categories or paradigms of awareness, in this case including types of interaction, the consequences of these interactions, and contributing factors. Each category was richly illustrated by vivid real life events from the people in their study. The authors' presentation allowed the readers to become sufficiently caught up in the description of their work to feel that they had been in the field, a technique of presentation that Glaser and Strauss highly recommend.

Glaser and Strauss put much emphasis on theory as an ever developing entity and not a perfected product. Theory emerges in much the same way as an hypothesis and can be integrated into categories and properties which are open-ended.

Another study, by Becker, et al. (1961), was useful to this project from the standpoint of the grounded theory method of study and the study of transactions. Their concept of symbolic interaction showed that

human behavior needs to be understood as a process in which a person shapes and controls his conduct by taking into account the expectations of others with whom he interacts. Becker's exploratory work was concluded with the attitudes and perspectives of people toward each other and the resultant teaching-learning transactions. Like Glaser's work, their work gave the reader ample opportunity to draw conclusions.

One final concept which follows closely much of the methodological approach of Glaser and Strauss is that of Guba and Lincoln's (1981) work in naturalistic inquiry or evaluation. Guba stated that naturalistic inquirers focus upon the multiple realities that, like the layers of an onion, nest within or complement one another. Each layer provides a different perspective of reality and none can be considered more "true" than any other. It focuses on differences as well as on similarities and leads to the development of an idiographic knowledge base, that is, one focusing on the understanding of particular events.

Naturalistic inquiry was defined by Tymitz and Wolf (in Guba, 1981) as the understanding of the "actualities", social realities, and human perceptions that exist untainted by the obtrusiveness of formal measurement or preconceived questions. It is a process geared to the uncovering of many idiosyncratic, but none the less important, stories told by real people, about real events, in real and natural ways. Naturalistic inquiry attempts to present a "slice-of-life," representing as closely as possible how people feel, what they know, and what their concerns, beliefs, perceptions and understandings are. Naturalistic inquirers, in an open and exploratory stance, seek a perspective that will lead to the description and understanding of phenomena as wholes or

at least in ways that reflect their complexity. The inquirer is the instrument, the data collector, the data analyst, and the interpreter.

The conceptual models of this project focus on informal teaching-learning transactions (Leichter), the framework for evaluating communication (Havelock), the process of effective communication within a teaching learning-transaction (Rogers), the social and environmental factors affecting the transaction (Rogers, Leichter, Guba and Lincoln) and finally, the conceptual models of methodological approach (Glaser and Strauss, Guba and Lincoln, Becker et al.). It was these models which served as the basis during the course of this research and as the framework for this final Major Applied Research Project presentation.

Major Issues and Research Questions

This research focused on the discovery of elements of theory regarding female nurse-female physician teaching-learning transactions. Teaching-learning transactions were investigated from the standpoint of types, quantity, quality, and communicative process within the transaction, such as openness and reward. The main focus here was to define and assess the strengths and weaknesses of this process itself.

Since this project concerned itself with women, as they are involved in teaching-learning transactions, women's or feminist issues were important. Here the delineating problems or strengths centered around the barriers and facilitation between women, linkage, homophily/heterophily, marginality, reward, hostility, expectations, perspectives, and mediation.

Relevant also was the issue of social and environmental factors. This issue was directly related to both the teaching-learning transaction and the participants in it. The nature of problems explored here was related to the effects and scope, be it individual or system, of social and environmental factors on the facilitation or barriers to teaching-learning transactions.

It should be noted here that extensive literature searches had already been done relating to this topic. While there was extensive work on women, most focused on equality and gender injustices. Very little related distinctly to women's relations to women. Furthermore, in studying female physicians and female nurses as a relationship, there were virtually only two cursory resources found which addressed this. It seems then of little surprise that nothing was found regarding the informal teaching-learning process among these women. This all pointed to the exploratory stance of this research. Therefore the major research question centered around the discovery of social and environmental factors which affected the teaching-learning transactions between female physicians and female nurses. In other words, what were they, why did they exist, how did they exist and affect the process, and who did they benefit or hinder?

Limitations of the Study

Since there were no quantitative parameters in this research, no limitations were factored out in this area. Possible limitations included the following: First was the professional role of the interviewer, which was that of a nurse. There was a potential that

female physicians, because of certain negative feelings toward nursing and the inherent personal sensitivity in divulging these feelings, would be hesitant to relate information to the interviewer.

A second limitation was the lack of actual observation in the field. This posed the question, "To what extent does an interview statement correlate with actual observable realities?" This research relied heavily on the perceptions and perspectives of the interviewed population, which were considered truth. Substantiation of that, in this case, was only possible from other interviews. Further limitations were found in interviewee's accurate recall of past events.

Assumptions

The main assumptions of this research included that:

1. All interviewees would be truthful;
2. Experiences would be shared as accurately and completely as the interviewee recalled;
3. Interviewees would be motivated to participate in this research.

CHAPTER 2

REVIEW OF RELATED LITERATURE

Social and Environmental Barriers and Facilitators to Informal Teaching-Learning Transactions Between Female Nurses and Female Physicians

As stated in the introduction, the women's movement for equality and choice has been a major contributing factor in the increased application and admission of females into alternative professions including medicine. The world is opening for women to choose from among the vast array of careers. Even the TV show Sesame Street, written for the two to six year old, depicts women as bulldozer operators, firemen, dentists, veterinarians and the like. Only 20 years ago, the major primer reading books were Dick and Jane, where Dick did while Jane watched.

How has the women's movement affected nursing? Muff (1982) believes it has both helped and hurt. The new and changing role of women has helped influence nursing education curricula dramatically. Not only is the nurse more educated than in the past, she is instilled, if not bombarded, with books calling for nurses' increased power, pride in the profession, and a larger share of health care power. Grissum's

(1976, p.16) Womanpower and Health Care was a bestseller among nurses and promoted assertion training concepts of self-esteem. She stated that

> it is impossible for nursing to achieve real professionalization, or to assume control over ourselves as individuals and collectively, or to take more active roles as innovators and instigators of social change, or to develop a career-orientation until we have elevated the position of all women--and of nurses.

Hoekelman (1975) said that there are many gains the women's liberation movement has made in its fight against male domination and female suppression. He went on to say that this will probably do more toward solving the doctor-nurse problem than anything we can do within the professions.

But Muff (1982) also believes the women's movement has taken a slap at nursing. As women become aware of burgeoning potential, they have abandoned traditional roles. Present literature on career choices for women often do not even mention nursing. One chapter in Muff's book is entitled "You want to be a nurse? Why doesn't a smart girl like you go to medical school?"

Furtharmore, many within the nursing profession resist the change to autonomy. This has been the cause of much internal friction within nursing. According to Kramer (1974), 33 percent of all nurses leave nursing permanently within three years of graduation, and 25 percent of these are totally disenchanted with nursing. Because nursing continues to evoke traditional images, and many nurses do not want nursing to change, women who seek creative, exciting, and autonomous careers go

elsewhere. Many who want to see it changed feel it is easier to just leave.

Reece (1961) looked at the attrition rate of nursing students. Those who withdrew scored higher in terms of achievement, autonomy, and dominance, but less in deference, nurturance and endurance than those who remained. Obedience and subservience of nursing students continue to be the preferred behavior of nurse educators. Therefore, those who are most likely to become true professionals are driven out. The bright and assertive are most likely to be factored out by a "Catch 22" syndrome. It is no wonder the term "silent majority" may be applied to nurses. They comprise 70 percent of all health care professionals, yet wield minuscule power, and many would say this is self-perpetuating.

Much examination has been focused on women who have moved out of the traditional female professions and occupations to seek careers, such as medicine. It is interesting to note here that, due to the newness of women in medicine, much research is being done on female medical students. Studies range from assessment of aggressive tendencies, to discrimination by male students, to measuring female medical students' libido levels. What has been discovered, in a statistical sense, is that women who have attained professional success are deviants (in the sense of being in the minority) and the significance of these deviations is important. Wietzman (1982) and Lasky (1982) found that in most instances, achieving women had a mother who worked outside the home, had especially close relationships with their father, were not content with traditional female roles, and were not consistently pushed or restricted to feminine activities. Muff (1982) also found that a great many of

them were the first born and much older than other siblings, or the only child.

Self-esteem and achievement are clearly related. For women, the development of a healthy self-esteem can be clearly related to their gender. Muff (1982) stated that 83 percent of all parents preferred a male baby as their first or only child. This is because society sees females as less important than males; therefore, there is a decreased social status and respect for the female role. Even in 1980, Lasky (1982) found that 77 percent of the public concurred that a female should put her husband's and children's needs before her own. The traditional female role is devalued in our society. Consequently females may learn not to value themselves and therefore, may have decreased self-esteem.

Socialization is the process whereby values and expectations are transmitted from generation to generation. Within this socialization process lies the foundations for future behaviors. The traditional socialization of women is to be passive, dependent and nurturing.

This can be seen in a study which looked at the concepts of femininity and masculinity. Sandra Bem (in Caplin, 1981) developed the Bem Sex Roles Inventory where she asked people of both sexes to look at a list of 400 personality characteristics and to say how desirable each one is for a woman and how desirable each one is for a man. Bem identified a characteristic as feminine if people of both sexes considered it more desirable for a woman than for a man; she identified a characteristic as masculine if people of both sexes considered it more desirable for a man than for a woman. The top 20 "femininity" items were affectionate, cheerful, childlike, compassionate, does not use

harsh language, eager to soothe hurt feelings, feminine, flatterable, gentle, gullible, loves children, loyal, sensitive to needs of others, shy, soft-spoken, sympathetic, tender, understanding, warm, and yielding. Ten of these characteristics are synonyms of "nurturant" or obviously directly related to it.

Consider the contrast between the "femininity" items and those which were classified as "masculine" in the same research. Inspection of the following list shows that none of the items is synonymous with nurturant, and quite a few would block nurturant behavior: acts as a leader, aggressive, ambitious, analytical, assertive, athletic, competitive, defends own beliefs, dominant, forceful, has leadership abilities, independent, individualistic, makes decisions easily, masculine, self-reliant, self-sufficient, strong personality, willing to take a stand, and willing to take risks.

This is not to imply that nurturance is considered a negative trait for women to have. But as women begin to compete in new careers not open to them only a few years ago, or change the direction of their place in traditional careers, this socialization process does indeed become an important consideration. For instance, a woman's ability to nurture may, in fact, present a very positive force that women can contribute to their professions. But nurturance carried too far can reflect passivity, or an inability to express or deal with anger, causing decreased effectiveness, and even serious problems for professional women.

Dr. Alexandra Symonds (1976), a psychiatrist, pointed out that increasingly, successful women are seeking therapy with only women therapists. These women may have challenging and high-paying jobs but

many find much difficulty coping. Symonds said that these women have been pressured from early childhood into dependent and submissive roles-the female stereotype. Once into jobs requiring new qualities, and wanting growth and self-expression, they often have conflict, either retreating to neurotic dependency or lashing out, particularly at men. Having heretofore spent a lifetime keeping hostile or resentful impulses subdued they now bypass healthy self-assertion. The side effects of their dependent personalities and unresolved dependency needs often have them responding in inappropriate or ineffectual ways, overreacting to even the slightest hints of inequality, or perpetually trying to prove their worth. Furthermore, Symonds said they tend to devalue all women whom they see as unsympathetic to their needs.

A discussion of the barriers among women is worthy at this point because of the potential implications for women working together. Dorothy Jongeward (1976) asked a group of 500 women at a conference, "How many of you would like to work for a female?" Only a few hands were raised. Women are too emotional, bossy, and "they can never make up their minds," were a few of the solicited comments. Jongeward then asked, "How many of you aspire to be a manager?" Many hands went up, and as the women looked around at all the raised hands, they realized, most for the first time, the extent of their own self-prejudice.

It has been said that women are their own worst enemies, that women resent other women's success, and that women resist working with a woman as a supervisor. Such arguments (Myhr, 1980) are sometimes presented as evidence that any movement to expand women's role in society is doomed to failure, as the masses of women themselves are somehow instinctively opposed to anything other than the status quo. On the other hand, we

occasionally find would-be reformers resentful of those women who fail to see the "obvious" fact that existing female roles are a ghetto that improperly deprives women of the opportunity to participate equally with men in the affairs of society.

In a now well-publicized article "Are Women Prejudiced Against Women?", Goldberg (1968) reported findings answering his question in the affirmative. His data indicated that college women evaluated articles allegedly written by males of various professions more positively than the identical articles attributed to female professionals. Aronson (1972) referred to the Goldberg study as demonstrating that women have been taught to consider themselves intellectual inferiors of men. However in 1975, Levenson, et al., refuted much of Goldberg's study, for reasons which reflected the changes over time in the evaluation of females by females. They gave significant credit to the impact of the women's rights movement, which has so emphasized the abilities and accomplishments of women. But even in spite of the recognition of accomplishment which may now exist among women, what about the hostility toward those accomplishments or toward those who haven't accomplished?

Muff (1982) believed that women who have succeeded, or are trying to succeed in a masculine, and often hostile environment, frequently look with scorn at traditional females as the cause of men's antifeminine attitudes. Heilbrun (1979 p.42) noted that the distressing attitude of achieving women is "I made it, why can't you?" She goes on to say that, "This failure to sympathize with the struggles of less vigorous female selves has always marked professional women. They refuse to understand the tokenism that they represent."

When the goal is masculine approval, females can become rivals and work against rather than with each other. And women who have succeeded in non-traditional spheres often demean their own kind and fail to identify with their own group. This is poignantly described by Francoise Giroud (Heilbrun, 1979, p.53), France's first woman cabinet member. When asked if she were a feminist, she said,

> No, not at all. Girls bored me. I found them dull and tiresome, with their endless stories...I was the traitor, the one who had gone over to the men's camp.

Kennedy (1970, in Morgan) called this denigration of other members of one's group "horizontal hostility." Women, like some minorities, have been forced to identify with a group that is devalued. Self-hatred and hatred of one's own group result. Women then repudiate their background saying, "I am not like them." They therefore identify with the dominant group and many actually assume the desired or envied qualities of males for themselves, hence overcompensating for their supposed weakness or helplessness. Kennedy goes on to say they actually take on the attitudes of men, including their attitudes about women.

In growing up, many women have watched their mothers cleaning refrigerators and doing other mundane housework, leading them to internalize those values that women are second best. This leads to a disparaging attitude toward their own kind and subsequent rivalry among females. Successful women will then associate with males and/or other professionals, rejecting any and all "kitchen talk," etc.

Hochschild (in Kundsin, 1974) described the professional woman as the "cutting edge" of the female minority group, thus being more

marginal than women who live in the more segregated world of homemakers. Hochschild described a person as marginal when they are striving to leave the racial or ethnic group from which they were born. Leichter (1978) described this same concept as a process whereby individuals are between different cultural or status groupings, particularly those related to upward mobility. In doing so they get grudging, uncertain, unpredictable acceptance rather than absolute rejection by the group they are attempting to join. The consequences of this are defeminization and deprofessionalization.

In defeminization, a woman feels she must prove herself somehow different from what other women are thought to be like, in order to maintain a professional identity. Therefore, if other women do this, she does not. This same behavior begets rejection from women of a traditional ilk. Deprofessionalization undermines one's professional identity. Similar to defeminization, deprofessionalization denotes that one's identity is rejected by others, and sometimes unwittingly by oneself. "She used her sex to get the job" is an example of this. Talking only about babies, recipes, and other traditional female topics with other women at parties is another.

The importance of attractiveness is yet another aspect of our society which influences the value structure of young girls and begins to set up barriers. Its stress in our culture is virtually inescapable. Commercials, beauty pageants, movie stars, and magazines all display it, perpetuate it, and advertise it. This focus on attractiveness sets up women against women because one who is more beautiful becomes better than other women in ways that men consider important.

Hence competition between women becomes vividly reflected in their competition for men. Since many have learned that worthiness is contingent on getting a husband, much energy is directed towards this endeavor. Each year millions are spent on make-up, jewelry, and clothes to make one look better, more attractive, sexier, happier, successful, sophisticated, and so on. Recently, books have been written on the psychology of clothing, particularly women's, as a means to attract and sustain a man's interest. Muff (1982) used the example of tight corsets and huge petticoats worn in the 1800's. They were invented to emphasize the waist, and in attracting men, smaller is better. Muff went on to describe how these clothes prevented movement and sports activity. "No wonder doors had to be opened for them!"

The popular fairy tales that all of us have heard also inculcate an underlying sense of helplessness in women. Cinderella and Snow White are two classic examples. Both are beautiful (which is always important if you're helpless). Both are surrounded by either ugly, vain, and mean stepsisters or the beautiful, jealous, vain, and mean queen (all other women). Neither, of course, can control their fate and even in spite of their circumstances are always kind and sweet, the epitome of selflessness and deprivation. In the end, however, these virtues win out and both are rescued by a rich, handsome prince who sees to it that they live happily ever after. Both are even prepared to assume the role of wife, as Cinderella has cleaned and cooked for her stepfamily, and Snow White found seven dwarfs for whom she could clean and cook in preparation for her ultimate role. These seemingly harmless fairy tales have, in fact, a very harmful twist and continue to fit women into a

mold which perpetuates the myth that finding a man (especially a rich and handsome one) is her key to fulfillment.

Sparkling personality, good looks and feminine demeanor are all prerequisites for marriage and the aim of the socialization process for many women. It teaches women to hate women by making them competitors for a man's attention.

Understanding the existence of barriers and the concepts of horizontal hostility, marginality, defemininization, and deprofessionalization is necessary in a study of women. Its relevance to this proposed research is twofold: first, will these barriers affect the informal teaching-learning transactions between women in medicine and nursing? And second, what form will they take?

Research within the nursing profession shows strong evidence of barriers and hostilities. Some nurses are career-oriented, have become highly educated, and have goals and aspirations for seeing nursing evolve into an autonomous achievement-oriented profession. To them, there are unfortunately far too few nurses who choose to follow this path, actually detracting from, rather than adding to, a true professionalism in nursing. McClure (1984) even differentiated white collar and blue collar nurses. But to the public a nurse is a nurse, no matter if one has a Ph.D. or merely one year of technical training beyond high school. So within nursing there are vast differences of preparation contributing to the dissension. Many achievement-oriented nurses will even disassociate with nursing by calling themselves educators, administrators, etc. They see nursing as second-rate and choose to affiliate with another group.

One can see that barriers potentially exist between women at many levels; between working career-oriented and non-working traditional women, between women within a similar profession and between women of various professions. Furthermore, these barriers are, at least in part, related to educational degree attainment, socioeconomic levels, power, and a successful career orientation. .When relating these to women in medicine and nursing, the first three of these, degree attainment, socioeconomic levels, and power, set most nurses apart from female physicians. Furthermore, while the female physicians' gender identifies them with the largest, yet least powerful group of health professionals, that of nurses, their profession nonetheless coincides with the substantially male-dominated, and decidedly the most powerful counterpart in the medical field, that of physicians.

The existence of barriers among women does not negate the existence, even the simultaneous existence, of bonding. With regard to nurses and physicians, their gender similarity, amidst their differences in incomes, status in society, and education, can reflect significantly in their interpersonal interactions.

In understanding bonding, one can first look at the concept of minority. For women, minority is not in numbers, but as members of a group feel that they are judged collectively rather than as individuals. This stereotyping in part implies awareness of differential and unequal treatment and discrimination, and prevents the full inclusion of rights accorded to others. "Just like a woman" is an example of this stereotyping and many women feel that this prejudice has prevented women from obtaining various jobs, positions, or respect in society.

According to Lee (1981), members of a minority exhibit some common characteristics once they become aware of their relative position in society and become determined to change it. Two of those characteristics are their awareness of exploitation and the resultant sense of identity, oneness, and esprit de corps. Therefore an alliance to women follows discontent, particularly as individuals feel they will not be permitted to reach a goal in society which they feel they are capable of reaching, and have the right to reach.

As Freeman (1975, p.452) stated in her book Women: A Feminist Perspective

> Once women have come to see themselves and other women as essentially worthwhile and interesting, their views of themselves and the world are never the same again even if they never participate in any women's movement. Women come then to believe that they are the way they are because of society, and they can change their lives significantly if they change society. These feelings in turn create a consciousness of oneself as a member of a group and the feeling of solidarity so necessary to any social movement. From this awareness comes the concept of "sisterhood."

Of course many women do not participate, formally or informally, in efforts to elevate their status. Many even fight against any movement which aspires to the equality of women. Yet this does not necessarily sever the bonding among women. A study by Welch (Baker, 1980) found that those who expressed opposition to "women's liberation" nonetheless agreed with an average of 10 out of 17 goals of the women's movement. Welch concluded that those against "women's lib" are not necessarily opposed to the issues of equality and justice, as they are offended by the notions and tactics of some organizations.

There is a long history of women working together to change their destinies. Their struggles have included the right to vote, the right to participate in politics, the rights of employment and education, and most recently, the right to be considered equal under the constitution. Most women who have had more doors of opportunity open to them, know that it is in part due to the past work and struggles of women before them. The dramatic increase of women in medicine, as well as the change in the responsibility and respectability of nursing, are at least in part a result of the women's movement.

The issues of women's bonding need to be considered in the transaction process between women in medicine and nursing. Indeed it has been addressed. McGoldrick (1984, p.114) a female physician and editor of the Journal of the American Medical Women's Association brings this to light when she wrote in the same journal her acknowledgement of the difficulty of the nursing profession in achieving recognition, status, and economic rewards for their services. This is complicated by the sensitive issue of the fluid role of women in today's society and has led to an uneasy, often adversarial relationship between nurses and doctors. She further elaborated that it is imperative that physicians get involved in innovative and creative ways of redefining the nurse's role, both as colleague and wage-earner.

> And, as women physicians, we have a special obligation to be committed to these objectives. Indeed, the struggles of nurses to be recognized and respected represent in large measure women's quest for equality. We should talk with them, rather than down to them; they are our partners in the care of the sick.

This bonding was further apparent in initial exploratory interviews with female physicians. All interviewees felt that the female physician-nurse teaching-learning transaction was different from the male physician-nurse transaction, and this difference was mostly reflected in positive ways. The following paragraphs depict a partial synopsis of these interviews with respect to the bonding inherent in these transactions.

As a whole, the female physicians felt that there was more time spent in the teaching-learning transaction, more mutual two-way sharing, and more listening. All of these female physicians felt that they contributed more than their male colleagues to enhance the communication process with nurses. Some did this by relaxing the climate in which the transaction took place, subscribing to such things as mutual first name salutations. All felt the female M.D. offered to assist the nurse more with nursing tasks which was met with very positive enthusiasm. They likewise felt that female M.D.s gave more compliments and recognition to nurses, which consequently enhanced future transactions. Finally, these physicians felt that the psychosocial needs of the patient and family were discussed more between themselves and nurses than between male physicians and nurses.

The women physicians who presented or confirmed the above examples, felt that these contributed to more quality transactions, better reports by nurses in regard to patient status, and more teaching and learning between the two professions. Some excerpts of their conversation, in relation to bonding, follow.

I've learned a lot from nurses about their approaches to patient care. A physician's education is geared to what's going on inside the body and what you can use to help that body towards health. A nurse's orientation is different. The most rewarding thing about the teaching-learning transaction is you feel like a team with that woman.

I think there is a kind of sisterhood inherent in the transaction. Only recently could you articulate it, but I think we've always been rooting for each other.

Illness is more natural to women. Men put illness up on this scientific pedestal. Women have taken care of their sick children and have experienced childbirth. Most male doctors probably never took care of a sick person when they were growing up. I think this commonality of a woman's view of illness strengthens the teaching and learning situations.

For the most part, my relating to nurses is on an equal basis and I contributed 50 percent or more to seeing that this was sensed by the nurses. "We're equals so let's see how the patient is doing."

I will do a lot for myself rather than ask a nurse. I also help out more with the care of the patient. I think most female M.D.s are this way. We're symbolically saying to the nurses that generally they do a lot of stuff that one doesn't get credit for. Same is true at home; scrubbing the floor, etc. Generally no one comes along and says thank-you. I'm a homemaker too and I know it takes time and it's a pain in the neck. I relate to the "scut" work in nursing and nurses overwhelmingly express their appreciation.

When a nurse approaches a female physician regarding a patient psychosocial problem, I think we're more empathetic. I'm interested in this and other female M.D.s I've worked with are also. Sometimes I wonder if male M.D.s allow themselves to get that involved.

I let the nurses see my vulnerability which male M.D.s do not. Nurses then can see where they can be helpful to us. This breaks down a lot of barriers.

My experience is that the male physician could care less about discharge planning. Nurses in public health will tell you a male M.D. doesn't utilize their services like a female M.D.; it's more business-like instead of a mutual problem-solving transaction.

I went out of my way to take down the traditional doctor/nurse barriers and try to make myself on an equal basis--in a working relationship as opposed to someone dictating something.

Abraham Maslow (in Kidd, 1976) once said that every experience is learning, and this influences who one is and who one can be. The characteristics of individuals and groups are a composite of these past and present experiences. This research looked at some of those social and environmental characteristics especially with respect to gender in an attempt to see how they affect a particular teaching-learning transaction, namely the one between women in medicine and nursing. As expected, there was found, in part and in combinations, various degrees of empathy, admiration, sympathy, envy, effectiveness, hostility, barriers, and bonds within this transaction. Yet through this discovery and analysis, there will emerge understanding, and hopefully a dynamic positive colleagueship.

CHAPTER 3

PROCEDURES AND METHODOLOGY

The format of this Major Applied Research Project was exploratory qualitative research using the concepts of grounded theory and naturalistic inquiry. This was carried out by major use of the open-ended nonstructured interview process. From the vast number of diverse facts, a theory was formulated.

A few structured questions were used in the beginning of the interview process, and as the interviewer deemed necessary, to assist problem emergence. However, these structured questions (see Appendix A) changed or altered as interviewees identified barriers and facilitation to the teaching-learning transaction among female physicians and nurses. The reason for this was that, as data emerged, one wanted to follow those leads in subsequent interviews, hence new questions were used.

Since this research was exploratory in nature, no hypotheses were tested. Rather, propositions came from the data during the course of the research. Likewise, variables and relationships between variables were discovered during the research. As Guba (1981) noted, when concepts or characteristics are yet to be discovered, it is not possible

to state them precisely beforehand and measurement is impossible, since an entity must be detected before its size can be assessed.

This research sought understanding by attempting to see the world as the subjects saw it. Their perspectives were accepted as being truthful, with an inherent understanding that people view, interpret, and evaluate things differently. Dexter (in Guba, 1981) reiterated this by delineating this form of interviewing to involve an emphasis on the interviewee's definition of the situation, encouraging the interviewee to structure an account of the situation and letting the interviewee introduce, to a considerable extent, her own notions of what she regards as relevant. As a result, the interviewee was a teacher of the problems, the questions, and the situation.

The result was the production of a vignette of considerable depth. This, as Polit (1983) described, is absolutely essential when beginning work in an area, when exploring variations of opinions and when delving into a particular area deeply. All of these were applicable to the purpose of this endeavor.

Each interview was unobtrusively tape-recorded. The interviewee was informed of this, but was also afforded the opportunity to speak "off the record" if she wished. All taped interviews were transcribed. A journal was also kept of each interview, and entries were made immediately after the interview. The journal recorded striking, non-verbal expressions or behaviors of anything said on or off tape, details of issues probed off tape, and researcher's ideas. The journal and taped transcripts served as the data base for later analysis.

Female physicians and nurses were the participant population. Further selection criteria included:

1. Individuals whose undergraduate and graduate education was obtained in the United States. This was to control for the affect of cross-cultural factors relating to women;

2. Those who had worked in a hospital setting within the last two years for at least two years because the importance of recent association was vital to this process;

3. Those who had professional contact with at least five individuals from the other category of the participant population. Contact with less than five was considered too little to establish a perspective of merit.

Most interviewees were sought out via professional contacts. Each was then contacted by phone or letter to further describe the project, assure confidentiality, verify that the interviewee candidate met the requirements for selection (as listed above), and confirm a date and time. After the interview was over, a thank-you note was sent.

Fifty interviews were conducted, which consisted of 27 female physicians and 23 nurses. The interviews were conducted in Miami, Hershey, Pa., Atlanta, Washington, D.C., New York City, York, Pa., and Salisbury, Md. Furthermore, a range of work situations with regard to type and size of institution was sought.

The following tables represent the demographics of both the nurse and the female physician populations that were interviewed. This is included because many comments made during the interviews were related to either their age, status as a parent, type of hospital they worked in, and their professional or employment status.

Table 1
The Number of Nurses and Female Physicians
in Each Category by Age

Profession	20 - 30	30 - 40	40 - 50	50 Plus
Nurses	4	13	5	1
Female Physicians	7	15	3	2

Table 2
The Number of Nurses in Each
Category by Specialty

Obstetrics/ Gynecology	Dialysis	Medical/ Surgical	Pediatrics
3	1	2	6

Emergency Room	Intensive Care (Medical/Surgical)	Nursing or Patient Education
1	6	1

Research	Outpatient Clinics	Psychiatry	Surgery/ Operating Room
2	2	1	1

Table 3
The Number of Female Physicians
in Each Category by Specialty

Obstetrics/ Gynecology	Surgery	Orthopedics	Oncology
1	1	1	1

Anesthesia	Pediatrics	Internal Medicine	Family Practice
1	2	12	3

Infectious Diseases	Emergency Medicine	Dermatology
1	1	3

Table 4
The Number of Nurses and Female
Physicians in Each Category by
Type of Hospital Employment

Profession	Teaching Hospitals		Private Hospitals
Nurses	18		5
Female Physicians	21		6
	Residents in training	Attending or Faculty	
	11	10	

Table 5
The Number of Nurses and Female Physicians in Each Category by Marital and Parental Status

Profession	Married	Single*	Mothers
Nurses	10	13	12
Female Physicians	16	11	15

*Single includes never married, divorced, or widowed.

The interview format consisted of a prepared introduction of the research project, including the interviewer's role, why the respondent was chosen, and assurances of confidentiality. Interview techniques were employed to maintain an open, productive, and in-depth dialogue.

Interviewing techniques were not taken for granted in this project. Training and competency feedback to the interviewer was considered crucial to this research. Therefore, two practice sessions were established, one from each participant group. After each session the interviewer solicited feedback from the interviewee in the following areas:

1. Courtesy;
2. Listening abilities;
3. Clarity of introduction of self and project, assurance of confidentiality, telling interviewee why she was chosen;

4. Value-neutral comments;
5. Use of controlled, nondirective probing;
6. Physical arrangements of interview;
7. Rhythm of interview;
8. Ability to frame questions;
9. Open versus closed questions;
10. Use of probing questions;
11. Sequencing of questions;
12. Pretesting the few structured questions for ambiguities.

Interviewer feedback also came from listening to the tapes during the course of this project. Guidelines for the interview format and procedure were derived from Guba and Lincoln (1981) and Cannell and Kahn (1968).

Analysis of Data

The interviews were analyzed in three stages. First each interview was viewed as a separate entity. As previously mentioned, this included a tape of the interview and subsequent transcription, and an interviewer log which included non-verbal communication, observer comments, reactions, ideas, queries, and the like. From this, a summary was formulated as a process of identifying issues and concerns.

Grounded theory requires that data be analyzed data as they emerge, so that emerging categories can then be followed up in future interviewes and that theoretical propositions can emerge in this process. Therefore it was important that review of interviews occurred on an ongoing basis.

The second stage included analysis of the interviews as a whole context. This process was characterized by further study of similarities and differences of the interviews, and continued the process of identifying issues and concerns, and coding these data. Again, since this was exploratory research, coding and categories emerged from the data.

The main scope of this total analysis was the continued discovery of categories from all the interviews, and consequent determination of their scope and significance. The larger the scope, the more criteria were established justifying the formulation of a category, or the conceptual elements of a category known as properties.

However, the repeated verification of specific barriers and facilitation from interviews, while important, was not the sole goal of this work. Idiosyncrasies were likewise analyzed. Guba (1981) stated that naturalistic evaluation is aimed at a search for meaning, and consequently a search for multiple realities, truths, and perceptions. Therefore, the person who had a singular viewpoint because of her expertise, position, or insight was assessed in the context of this whole analytical process. Glaser (1966) stated that a concept or theory may be generated from one fact, which then becomes merely one of a universe of many possible diverse indicators for, and data on, the concept.

The third stage of the analytical process was the most complex aspect of this research for it entailed the analysis of reams of transcriptions, field notes, ongoing coding processes and interview summaries. To make this process easier, it entailed color coding, cutting apart of transcription copies, and filing. This added

organization to the ongoing analytical task of identifying what the data meant.

As the categories developed, they were filed into two main sections; one for the female physicians and one for the female nurses. Initially 42 categories developed in each section, making a total of 84. Later, as more interviews were conducted, there were revisions, consolidations, and deletions, leading to 24 categories for each section or 48 total. Each category contained one or several properties.

As the categories and properties were identified, comparative analysis was employed to describe the participant population. This analysis was mostly between female physicians and female nurses. However, the importance of similarities and differences within each professional group was, of course, relevant and was not overlooked.

Numerous theoretical propositions developed from this research as the interviews progressed. This development was ongoing so any emerging hypotheses could be further explored in future interviews. Here is an example of this process. The seventh female physician interviewed made the following statement during her interview.

> I see a lot more kidding and joking between a male M.D. and the nurse. This doesn't occur between the female M.D. and the nurse. I think this is very much an underlying sexual phenomenon. Since this doesn't exist between the female M.D. and the nurse, the female M.D. has to find firm ground to work on and they have to be on a basis of mutual respect. Actually this may be healthier than the other with its sexual connotations.

This was new data and needed analysis before the next interview. The following are three hypotheses which were formulated after transcription:

1. There is less humor between nurses and female M.D.s than between nurses and male M.D.s.
2. Humor is used to reduce the stress of a tense situation or when one is uncomfortable in a specific interpersonal interaction.
3. Humor is used to attract attention particularly of the opposite sex.

The questions "what" and "why" figured foremost in this process. Therefore example 1 considered what the difference was, and examples 2 and 3 sought beginning explanations as to why there was a difference. By the time the next interview was scheduled, the issue of humor was ready to be followed up. And as new data from subsequent interviews emerged, more hypotheses followed and/or former hypotheses were revised or eliminated. These hypotheses could then be included with the planning of future interviews.

Frequently the interviewee was asked to respond to an actual quote, such as the previous one. When this was done, they were first told that only one other female physician or nurse had stated it, and were asked if they would react either positively, neutrally, or negatively to the statement. The quote was then read to them. This prompted a reaction and triggered thought processes which led to follow-up discussion and often in-depth dialogue on the subject.

Presentation of Data

The presentation of the findings is both descriptive and analytical. Presentation follows a codified process by category so

readers understand how theory was obtained from the data. In other words, it is a running theoretical discussion, using conceptual categories. This process includes vivid descriptions of the types of interaction between participant groups and additionally summarizes the extent of any conceptual framework serving as foundations in the transaction. All similarities within and between groups are presented first. Extremes or deviances follow.

Direct quotations of the interviewees are extensively included in this paper, and follow the theories and concepts formulated during this research process. Therefore, one is able to understand how the theory developed and to see substantial evidence to that effect. As both Glaser and Strauss (1967) and Cuba and Lincoln (1981) have stated, the reader of this type of research should feel that they have been involved in the process.

The data discovered in this research project fell into eight major sections. They are as follows:

1. Female physicians' and female nurses' perceptions of the teaching-learning transaction strengths between each other as women;
2. How respondents felt the teaching-learning transaction between women enhanced patient care;
3. Socialization and bonding
4. The issue of sexuality;
5. The emergence and analysis of barriers;
6. The effect of negative incidents;
7. Perception and introspection;
8. Variables.

RESULTS

(Chapters 4-11)

CHAPTER 4

FEMALE PHYSICIANS' AND FEMALE NURSES' PERCEPTIONS OF THE TEACHING-LEARNING TRANSACTION STRENGTHS BETWEEN EACH OTHER AS WOMEN.

This chapter deals with four categories which all pointed to strengths in the teaching-learning transaction as perceived by both the female physician and the nurse. These categories included setting the climate for the transaction, reward and evaluation, helping each other, and teaching and learning. Each category begins with the perceptions of the female physician and is followed by the perceptions of the nurse.

Climate Setting

Female Physicians

The female physicians interviewed felt that the climate for the teaching-learning transaction was important and that climate setting between women was different and more positive than between male physicians and female nurses.

> The atmosphere between the female M.D. and the nurse is absolutely more relaxed. This is good. Nurses are more willing to give to the female M.D.s because of this looseness. The female M.D. is definitely more approachable.
>
> Nurses come to me frequently and easily with a problem. So I think they feel I'm open. They won't pursue this with another M.D., if they've tried a couple of times and not gotten anywhere.

The climate between women doctors and nurses was characterized by less social distance and reduced authoritarianism.

> I suspect that more women than men have the style of, "What shall we do" as opposed to, "We will do this."
>
> I went out of my way to take down traditional barriers and try to put myself on a equal basis: in a working relationship as opposed to someone dictating something.

Female physicians felt that their role as a "physician" put them in a position to structure a positive climate, and they felt it was their responsibility to do so.

> Many nurse practitioners in my office request to work with me. I go out of my way to teach. It is easier for the physicians to remove the barriers because they are in power. I see the majority of female M.D.s doing this although there are always your extremes.
>
> As the relationship begins, nurses seem to be more timid and female doctors try to make friends. This is promulgated by doctors. Most female doctors are coming out of the 70's and women's awareness. They are trying to close those barriers.

When exploring why the climate setting was different, the commonality inherent in femininity was identified.

> Women can have friendships and participate in activities without feeling competitive. There are also more points of identity between female doctors and nurses. Female doctors need female companionship, and it is important to discuss things such as children, motherhood, household, and husband. Within this environment, people are comfortable asking questions.

In addition to there being a commonality among women, there was also less intimidation.

> People probably do think you are more approachable or open to suggestions if you are a women, or maybe it is just that you are not as imposing a figure.
>
> Nurses do feel more comfortable with us, and I've talked with other female doctors about this, because we are the same sex. It is easier to say, "Hey Debbie, can you come here..." With males it "Dr..."

Feelings of approachability, however, sometimes had negative consequences. This will be discussed in detail in Chapter 7.

> I do see a more relaxed interaction between women but sometimes this is based on a lack of respect or fear rather than because of a feeling of relaxedness.

Female doctors clearly perceived that this climate had a positive effect on nursing motivation and in patient care.

> I know the nurses like me and think I'm approachable, so many times they bend over backwards to help you get the stuff done. This works out to my advantage.
>
> It does boil down to personality but women doctors are perceived by nurses as being more approachable, so they are more likely to tell you that there is a problem.
>
> Female nurses will tell female doctors more often about little things they notice about the patient; "He ate his dinner, etc."

They describe it. Likewise they'll give us the detail of something, such as pain. If it was just a guy, they'd say he ate well today--if the person asks.

When I'm on call, I'll know more about the patients the next morning than their regular doctors do. Nurses talk to you more.

The teaching and learning process also benefited.

If you write an order and the nurses didn't understand it, I felt they were more comfortable in asking a woman for an explanation, so they could learn something, than they were from the male doctors that I saw them working with.

My personality is affected somewhat by being a woman. We are more approachable for asking questions or to have things explained.

Nurses

The perceptions of nurses regarding approachability were similar to those of female physicians.

A woman will develop an interpersonal relationship with a patient or colleague more quickly than man.

It is easier to talk to female doctors; they open up.

It is easier to talk to female doctors and easier to be assertive. Nurses can communicate honestly.

The female doctors knew the nurses by name.

There is definitely more talking between women. They don't hold back like the male.

It depends too on the personality of female doctors, but the majority of female doctors are more approachable. I can't say the same about males.

For nurses, approachability and reduced reliance on professional authority were attributed to gender similarity.

> I feel I can go to her a lot easier than a male doctor.
>
> It's like there's a professional barrier with a male doctor. It affects the way I approach them. I'm more comfortable with women.

The communication process between women was more personable, and this resulted in reduced social distance.

> Nurses tend to approach male doctors and female doctors differently. Male doctors tend, for the most part, not to be as caring sometimes or not to be as gentle. I feel a lot of them still have to uphold the macho-male image, not only with personnel in the clinic but also with patients. Female doctors tend to be gentle, more personal with patients, and with nurses, staff, and me. I can almost deal with them on a girlfriend basis. With male doctors, I feel you have to deal with them on a professional person-to-person basis. Whereas with female doctors (not all but most), I can deal with them in a professional manner, yet at the same time on a girlfriend basis. Female doctors are much more personable. They seem to feel that the little personal things about them are of interest to you--more so than male doctors. A male doctor would not come in and say, "You know, I'm real concerned about my child; I was up half the night with my sick kid." Whereas a female doctor who comes in, this would probably be one of first things she'd tell you.

In explaining the approachability difference, one commonality among women, motherhood, was a factor. This will be discussed at length in chapter 6.

> Doctors who are mothers tend to share similar experiences. This makes communication easier.

Intimidation was likewise a factor for nurses.

> It is easier to be assertive about my opinion with female doctors than male doctors, especially initially. When I've called some male doctors at night, they hated you for that and often made you feel stupid. Women are less threatening to other women in general.
>
> If you look at the relationship of the nurse and the traditional doctor, nurses were the handmaidens. Now female nurses feel more comfortable dealing with women. She doesn't have to feel that she is intimidated. It's more relaxed.

Respect was an issue and was reflected in a cyclical pattern. Because nurses viewed the female M.D. as approachable, they presented more information. The female M.D. respected this and continued to be approachable. Thus the pattern continued in future transactions.

> When I call a female doctor with an emergency-type thing, I think they are more reactive. Whereas males are more likely to say it can wait--take care of it in morning. Females are more likely to jump on it. This could be an aspect of respecting our opinion more, or the way the nurse passes on the information to the female doctor. Female doctors react differently, and are more alerted. With late night calls, I have gotten a, "Don't bug me" or "Don't call me about this again" from men. But not from women. I've never heard a female doctor say this to anyone.

The nurses felt that they played a role in facilitating the climate.

> Sometimes I use feminine types of facilitation, like a compliment, to put them at ease. Maybe a, "Hi- nice to see you. Your hair looks nice." (Something I wouldn't say to a male M.D.) It's a casual type of conversation that can go on between women. Most female M.D.s that I work with respond to this. It makes communication easier.

Approachability made nurses more comfortable in discussing patient care problems as they occurred.

> Nurses feel more comfortable calling up a female M.D. to talk about a patient problem (marital, etc.), and to talk about the emotional aspects of it. With men (at least older ones), we wouldn't feel comfortable. We might bring it up when he's making rounds, but we wouldn't call him up. It's looser dealing with female M.D.s.

The relaxed climate led to an increased desire to learn more.

> There is definitely more informal teaching. Nurses ask more "What's happening with this patient?" and don't feel bad about appearing ignorant. It's easier to say I don't understand. Nurses are more comfortable questioning female M.D. orders.

Nurses perceived that positive effects on patient care resulted from this transaction process.

> One can get to the bottom of something with a female M.D. If we have a problem with a patient, we're more likely to tell a female M.D. They understand better, and have more empathy for the patients. This is how I perceive it.
>
> Female M.D.s are more reactive to the problems that the nurses bring up about patients.
>
> I feel that a female M.D. is more in touch with patients as a whole. So nurses feel freer to approach her. She (female M.D.) will sit down and talk about it and try to see what she can do.

The positive aspects of approachability among females sometimes stemmed from mixed interpretations of the casual interaction among male M.D.s and nurses. This issue will be dealt with in much depth later (Chapter 7).

> If a nurse spends too much time asking a particular male M.D. questions, everybody thinks there is something else going on, like something sexual. Not so with females.

There were, however, instances of a lack of approachability among women. An example follows, but this will be dealt with in greater depth in chapter 8.

> It depends on our initial contact with a woman M.D. For example, this one came in saying, "I am Dr. so-and-so and I want Dr. so-and-so." Then nurses said they didn't know where he was. "Well I am Dr. so and so, and I expect you to find him for me!" This was our initial contact with her. She later apologized and was a more caring individual. Once we got to work with her, she was excellent--an excellent teacher. Easily approachable. No barriers.

Reward and Evaluation

The mutual recognition of, and reward for each other's work was an important evaluative component discovered in this research. Informal evaluation took several forms, such as complimenting, recognizing the work done by the other, and asking each other's opinions. Furthermore, this evaluative process transpired in a nurturing environment.

Female Physicians

> Compliments mean a lot. It's important to recognize the nurses this way. I think women are more comfortable doing it, therefore they do it more than men.
>
> Part of what made my relationships pleasant was my interest in people and commenting on something done well. I sensed that the nurses reacted to this. They would do the same for males who acknowledged they're "personhood," but generally I saw more women doing this than men.

Female physicians recognized that asking the nurse's opinion was something significant, but not frequently done.

> After I give orders to a nurse I always say, "Is there something else I could do or anything I have forgotten?" There is always a four second pause, like nurse saying, "I can't believe that she's actually asked my opinion." Almost always they are surprised.
>
> "What do you think?" I ask nurses. I don't see this with males.
>
> Nurses are always a little unsure of what women M.D.s will be like, but I think I respect them for working hard and they respect me for knowing that and for opening up and asking them to discuss things with me. This makes the teaching-learning transaction of good quality and based on mutual respect.

Nurses' notes are an important part of nursing care and are vital, not only from a legal standpoint, but to convey information about patients. Generally, however, nurses' notes are not read by physicians.

> I was trained quickly to ignore nurses' notes, "The nursing school is trying to make them into junior doctors." I remember when I went back to read them, the information was always there-- the real critical stuff.
>
> I read the nurses' notes everyday. The nurses recognize that I do this.

One reason for complimenting was the recognition of women as a minority.

> I always let a nurse know if she did something nice or something well. In knowing I wasn't getting a lot of nurturing and encouragement from my environment, I could figure she wasn't getting it either.
>
> We're still minorities in the work world. This makes us feel closer together.

Nurses

When nurses were asked about complimenting, they noted that it was important whether their opinion of a situation was solicited.

> I think a nurse is more impressed by a physician asking our opinion than anything else they can do.
>
> The female M.D.s usually come across by saying that this and this is presenting. "Have you (nurse) seen anything else which you can add to this picture?" They are leaving the door open and welcoming your observations. The male will say this and this is presenting but will not invite your comments. He will wait for more data to come in. He depends more on the scientific rather than on the relationship itself.

This affected future transactions.

> Nurses react to this positively, and the next transaction is progressive. It opens the doors to more dialogue.

Nurses saw male physicians complimenting, but differently from the female.

> Compliments? Female M.D.s are more likely to compliment on how well you handled something. They appreciate help and thank you for showing her this or that, or teaching. Male M.D.s are far more likely to say, "Wow, you know what you are doing." He compliments, but in a different way-- more paternalistic.

Compliments were also seen as a form of camaraderie, even egalitarianism.

> Women compliment more. Women don't have to put themselves on this ego trip. They are real people. They get a lot of respect.

But nurses sometimes had problems when female M.D.s carried opinion asking too far.

> One female M.D. gave me responsibility that exceeded my role. She even asked me to write orders. This was a compliment. (You know you can get to know a M.D. very well--a sympatico. You, in many cases, know exactly what they will order.) But legally, I felt uncomfortable.

In the nurses' perception, insecurity of a female M.D., and her need to prove herself in a male world also, took the evaluative component of complimenting beyond its bounds.

> One new female M.D. was unsure of herself. She was aware that the nurses knew more than she, therefore always asking nurses. The nurses were uncomfortable because they felt the pressure to know the answer. They would think, "My gosh, what if I'm not right?" It is one thing being asked about medications, etc., that I'm familiar with; another thing being asked medical things like, "What is wrong with this patient?" With this one female M.D., you knew whatever you told her to do was what was going to happen. She would not ask her male M.D. colleagues because she didn't want to appear less in their eyes. She was in a strong male M.D. practice as the first female in this practice. Most female M.D.s do ask nurses' opinion more.
>
> Female M.D.s tend not to be assertive enough with what they want to do. They leave too much of the decision making up to me (a nurse). I then ask them what they think? Insecurity happens to both female and male M.D.s but with the female, it's seen as passivity. Basically anyone who is insecure would really rather have no one else know that.

There was some deviance, even negative comments, on the issue of reward. Some nurses found no difference in the amount of compliments given to them by female M.D.s as compared with male M.D.s. Some felt there was a difference but not an outstanding one. Others felt that

younger male physicians were much more likely to compliment a nurse's work than the older, traditional physician.

Helping Each Other

Another form of complimenting took the form of offering assistance.

Female Physicians

> It is more likely that I would do something rather than ask a nurse. "Oh let me help you get this patient up." I would get feedback on situations like this that would encourage me to continue. They would actually say, "A male physician would never help this way. I really appreciate you doing this! Most M.D.s wouldn't take the time."
>
> The female M.D. does little things, in regard to comfort. Nurses work so hard to make patients comfortable, yet many M.D.s leave patients uncomfortable after examining them.
>
> I'm real careful about not making a mess or leaving patients uncomfortable after I examine them. I never want to make a mess for anyone else to clean up, if I can help it.
>
> I'm not bashful about getting a bedpan, or helping them on or off of it. Most males will get the nurse. It's different if there's a million things to do, but if you're there, how much effort does it take to help someone, rather than call a nurse who's off helping other patients.

Females routinely assisted nurses in ways that males often refused to do, or could not do.

> I've made beds and pushed patients around. If somebody is real sick, and there are not enough of us to get things done, I'll do it. Here at this hospital, you have to or the place doesn't function. The female M.D. does this more. I never saw a man make a bed.
>
> I've never witnessed a male helping a nurse with tasks.

> I think a male will do it only if he thought the nurse was having great difficulty. Certainly not routinely.
>
> I'm the best at scut work. I get so much information out of patients. All females do. Certain males will do this if they are sensitive. Women as a whole seem to be more sensitive.

Helping out facilitated the reduction of barriers to communication.

> If you can make a bed with somebody, you are more comfortable with them.
>
> When I first started out, I felt uncomfortable asking a nurse to do something because of the nature of the duties, and I didn't want to have them think that I was better because I was a doctor. (My insecurity.) Also I wanted to break down the barriers that I had heard were there and to show that we would do what had to be done. I found out later I wasn't supposed to do those things for a reason, because my time was for other things. But if I walked down the hall and heard a patient call for a bedpan, I got it. It has a lot to do with recognizing the scut nature of the job.

When female M.D.s helped nurses with their work, they perceived the appreciation of the nurses, and the results of that.

> Nurses react positively. Some are surprised we are willing to get dirty. They saw we didn't perceive ourselves as being God...we're human. I don't wait for the nurse. I help turn, take the temperature, and get the bedpan.

When asked about the reasons for helping out more, female physicians mentioned factors associated with socialization.

> I think it comes from just being a woman and cleaning up around the house. It comes from watching your mother pick up and you empathize with your mother. If you don't pick it up, somebody else is going to have to do it, and you know exactly who that is. The women house staff are less inclined to make a mess and leave it than the male house staff. Also we're more likely to turn a pillow

> because it's sweaty on one side, straighten sheets, or get a bedpan.
>
> Helping out? True. Why? Sexuality. Because men traditionally do not keep house. Their mother did it for them. Women automatically help clean and make less mess.
>
> Female M.D.s, because of upbringing, don't consider it beneath them to reach out and do whatever needs to be done if nurses are busy. To a male, he might feel he is a wimp or something.
>
> Being a woman and a mother I feel this way: Don't undo what somebody has worked hard at. I see other females doing the same. They ask the patient, "Do you need your glasses? Do you want your tray?" They set them up again in bed. I see this changing a bit with men because they are becoming a little bit more caring.

Perhaps related to socialization is the female M.D.'s greater attention to patient comfort.

> Yes, we do work harder to make the patients comfortable. We do little things which male M.D.s take for granted. They don't do.
>
> In pediatrics, I change the diapers all the time, not only for benefit of the patient but for benefit of the nurses.
>
> Women are definitely more in touch with trying to keep the patient comfortable. They keep the sheets clean (after the bed has just been changed) if they go to draw blood. Like I've seen women stop what they are doing and go look for a pad to protect the bed. With males, it's needles in the bed, the whole bit. They are just not in tune. Maybe they've always had someone to clean up after them.
>
> Women physicians will even help change the bed, or get the patient in and out of bed.
>
> Distinctly different with men. I've seen patients being moved from stretchers to beds and the male M.D. will walk off...probably not even knowing what they are doing.

Again, the commonality of women, such as motherhood, emerged.

Female M.D.s clean up after themselves. Males leave saying, "Nurse will take care of it." I am a mother too, so maybe this is part of it. We clean up after our kids.

The nurses are aware of this and appreciate it. They say it is because we are women; "These male M.D.s expect their mother to clean up after them."

I help out. Maybe it's because we're used to raising children and changing diapers. I don't consider this demeaning. I can't make a generalization that men do this less. I do see that surgeons and orthopods get in and out; they take off the dressing and leave. Internists are more involved. I'm in medicine to care for a patient. If egos get in the way, I get very impatient.

It also implied respect, and even empathy towards nursing.

It's an aspect of female socialization, but I'm doing it as a favor also. Therefore, it is not a totally automatic behavior of socialization. Part of it is a respectful behavior to the other people involved.

I was saying to the nurses that generally they do a lot of stuff that one doesn't get credit for. The same is true at home; scrubbing the floor, ironing, etc. For the most part no one comes along and says thank-you. In being a homemaker, I know that takes time and it's a pain in the neck. I relate to the scut work in nursing.

I told my male interns to clean up their messes.

Sometimes helping out became an aspect of passivity, or in some cases, a compensated reaction to the passive role of female.

A lot of women, if they have something to do, usually find out that the easiest way to get it done is to do it yourself, rather than spend the time to find and make sure somebody else does it.

I find myself always getting my own examining equipment on the floor or finding things that I need. I find myself not being assertive, or as assertive as I probably should be, in utilizing help available. I will do things myself rather than ask somebody to do them. This is distinctly different from a man. He'll <u>never</u> do this. <u>Never</u>. Many of my female M.D. colleagues are the same way, although I do see some of them going to the other end a little

> bit by being more demanding. They really make a point at not being deferring to the nurses. I don't see this happen too often.

Female physicians perceived that helping out was in part expected by the nurses.

> In obstertrics, female residents have to go out hunting for help when doing a pelvic. Both men and women need assistance; the extra pair of hands. Nurses, with female M.D.s, tend to say, "Well she can do it herself" because a lot of times we do. Female M.D.s will do a lot of things a guy wouldn't even think of doing, even to the point of getting the bedpan.

And if the expectations of the female M.D. and the nurse were not fulfilled, there were ramifications. Chapter 8 discusses this at length.

> Nurses are less forgiving of a female M.D. if she's sloppy. She's considered more insensitive if she leaves a patient undraped or the room in a mess.
>
> In regard to this, I personally have higher expectations of my female M.D. counterparts.

Patients also asked women M.D.s to help out more.

> Part of this is the patient expectation also. If a patient needs a bedpan, he or she will yell it out to a woman (nurse or M.D.), but they won't ask a male.

One result of helping out was acceptance.

> The doctors that try to be helpful are accepted more rapidly. I'm very well liked because I help out so much... Maybe that's the main reason I'm liked. I do most everything myself.

Two physicians from large, inner city, teaching hospitals felt little appreciation from the nurses. It became evident that the environment or working conditions influenced this. .

> To tell you the truth, I don't think the nurses really notice. I'm frequently with a patient at bedrest and I may try to get a urinal or bedpan, if none in room, from nurse. Invariably they get pissed off. No recognition that I'm trying to save them work later if patient wets the bed. Everybody is so dragged out. Even men get this unless they are a datable possibility. No, I don't think the nurses notice. I think they expect it of certain female M.D.s who they know.

The most frequently mentioned intervening variable in helping out was the type of hospital. Those from understaffed hospitals had little choice in whether they could help the nurse. If they did not, the work often did not get done.

> I can't speak in general. This hospital is unique and so understaffed that everybody has to help out. It's part of this inner city hospital.

Nurses

The nurses' opinion of the female physicians' participation in helping with nursing activities was similiar to the perceptions of the female physicians.

> Women physicians don't come along and do a treatment and leave a huge mess and just walk off and expect every little thing to be picked up behind them because that is their due and because they are doctors. They don't see it this way. They actually help clean up, or maybe not even make a big mess in the first place. Sometimes they can't avoid it. But men throw things on floor; they don't care. Female M.D.s don't expect nurses to come behind them with a wisk broom and dust pan. Very rarely see a female M.D. walk into the nurses' station and announce that she is going to do a treatment on a patient and expect every single thing to be there when she arrives, and for nurse to perform every function that she doesn't as a "doctor." Of course if she needs help, she'll ask. She gets this, while you get that. There's more teamwork. They help out with patients more than the male M.D.
>
> Female M.D.s definitely are more helpful in helping clean up. Men just leave stuff laying all around the place. Women make less mess. Helping? Definitely more. Women clean up after themselves. If they unwrap a baby to examine, they will wrap it back up. Men examine, leave diapers off, blankets open, and wait for the nurses to come and fix.
>
> It's messy; childbirth is not a clean thing. She'll change the underpad. She'll get them ice. She'll wet the washcloth and put it on their head. She doesn't have to do that. That's why nurses are there; the scut end of it. It's providing professional care but there are good parts and bad parts.

The effects of female physicians' attitudes was carried into patient care.

> I've had to scold more male than female M.D.s who leave needles uncapped in the bed. Yes, there are many times that a female M.D. is more concerned with a patient's physical comfort than a male M.D.

There was recognition among nurses that the female physician often helped out because nurses are less available to a female physician than they are for men.

> The female physician does help out more, however the nurse will allow the female M.D. to help out where she will jump up and do it for the male. Nurses don't have the same interest in helping the

> female M.D. and I think this is sexual; whether he is a prospective dating potential or not. It's just because it's male to female. It's social conditioning. I realized this about myself and when I did, I bent over backwards to help the female M.D. I felt I wasn't right and actually hated myself for doing it. I could see myself ignoring a female resident but responding to a male when he came to the floor. I see other nurses doing the same thing.

In some cases, helping out differentiated female physicians into those who would directly help with nursing tasks, versus those who did not, but were nonetheless willing to take responsibility for their own physician duties.

> I've seen very little difference between the sexes in the ICU (Intensive Care Unit) in regard to helping with patient care. They will tell a nurse if a patient needs a bedpan. However for a procedure that needs to be done, a female M.D. will be more independent to get what she needs. Instead of saying, "I'll be back to do this and have it ready," she may get her own equipment and medications.

As with female physicians, nurses felt that male's failure to help out was both an issue of ego, and a result of being unaware.

> Women definitely help out more. They don't think it's beneath them. Also some men don't even see that it needs to be done. They just walk in and walk out. All they thought about was what they had to do, not about the point that the nurse had to get things ready, get patient prepared, or talk to the patient about it. They do it and are gone. Then maybe the nurse has to reassure patient, plus clean up.
>
> Women do little things. They are not putting themselves on a pedestal. They help out; don't just go to get the nurse. Things are not revolting to them even if they are in their suit (i.e. a patient was vomiting; she grabbed basin and washcloth. She didn't call a nurse). I have seen in rare moments a male that has extraordinary compassion and will step out of this role to help someone. A women is more apt to do it because she doesn't view it as beneath her. On the other hand, to give credit where credit due, I have seen some male M.D.s do the same thing. But by and large the majority of the female M.D.s will automatically do it.

> Somebody will call for a bedpan and you're really busy, and it's not unusual for a female M.D. to give it. She'd empty them too! And you could go on to something else.
>
> I think women will help when they're there. It's a female's nature. For example in surgery, a male M.D. comes in just in time to do the surgery and leaves as soon as it's done. Female M.D.s tend to come in, speak to the patients more, help get the patients on stretchers, and go to recovery room with patients.

Hostility towards male M.D.s was evident from nurses on this issue. This increased appreciation for women who were not only considered more helpful, but also more considerate.

> I see female M.D.s come into a room to draw blood and put a chuck under the arm. They don't leave fresh blood on the bed and the sheet off the patient and walk out of the room and leave the needle on the bed. Female M.D.s are more attentive to cleanliness and comfort. I really believe this whole heartedly. Once a male M.D. left a patient connected to a EKG machine after doing it. Then he left the unit and said nothing to nurses. They didn't know if it had or had not been done and the patient was uncovered and cold. I queried him, and he said, "Look I didn't pay for four years of medical school to disconnect EKG machines." I said, "Well you may have paid a lot of money for medical school but you are not paying me to clean up after you." Now most male M.D.s disconnect patients from a EKG machine, but they will not clean the sauve off the patient. The female M.D. will automatically clean it off. The nurses did appreciate this and this added to the feelings of team.
>
> Yes- women tend to be neater. They don't leave a mess all over bed. They are also polite. They will ask a nurse if she would rather put on the dressing.
>
> Men leave a mess. It's rare to find a neat male. But nurses know what they can change and what they can't, so they have come to expect certain things. Nurses becoming a little more assertive (only with residents); "You are going to do this..." With attendings (faculty), they rarely confront. If they are too forward, they will get flack. So they play the game.

This issue, as with female physicians, pointed strongly to a socialization pattern for both men and women.

> Males just aren't as tuned in to picking up after themselves.
>
> Women are more intuned to doing things like helping out, whereas men, especially older men, tend to just expect certain things to be done. They don't know how they got done maybe, or they don't want to give any acknowledgement. They just expect it.

Nurses noted that female physicians who did not help out like the rest of their counterparts, often had a need for respect.

> Some female M.D.s feel they have to be more direct and give orders more. Others are the opposite: They pitch in and help. This has to do with the comfort they feel in themselves in their role. With one emergency surgery, a female M.D. prepped patient, helped scrub patient, and put in a foley catheter. When she was thanked by a nurse, she said it didn't matter who did it, it just needed to be done. This one was like this all the time. Others will get angry with nurses because the nurses are not working fast enough to get everything done. I don't think that female M.D.s, who do not help, are trying to assume the role of the traditional male M.D. Rather they assume the role that because they are a female, they can get respect not only from the nurses, but from the male M.D.s that they work with.

There were nurses who felt that there was no observable difference between the amount of help offered or given by female versus male physicians.

> There isn't really a gender difference. They all maintain the role of, "I'm the M.D., you are the nurse. This is my job, that's yours. I won't interfere with yours and I expect you to support mine as much as I support yours." Women may respect you more by asking for you opinion etc., but this is not carried so far as to help out more with nursing tasks. You don't see any hands on contact.

As with female physicians, nurses thought that the age of the physician was a significant variable.

The younger man helps more. He's more attuned to the patients' needs.

Teaching and Learning

There were qualitative differences between female-female teaching-learning transactions and female-male teaching-learning transactions. Women felt that the transaction was longer, of higher quality, and with more mutual listening.

Female Physicians

The female M.D. does more informal teaching.

Women are more patient and willing to explain the whys of an order. This gives more assurance that it will be done. I find if nurses understand an order, it's easier in carrying out. This way the ward runs better and everyone gets along better. The nurses say thank-you.

Perceived differences between the male physicians and female physicians were addressed by the female physicians.

I think there is more informal teaching partly because the female M.D. gets to know the nurses a little bit more. The male M.D. comes in saying this is this and this is that. There is less explaining.

We (women) get involved. Men need the audience.

Yes, I find the nurses asking me a lot more questions than I think they ask male M.D.s.

Queries as to why there was more informal dialogue between women drew the following responses.

> There is more dialogue with female M.D.s and nurses. This is probably true because women feel comfortable just chatting. Women like to just talk and learn from each other. This is a feminine characteristic.
>
> There is more dialogue and interaction. If we are just sitting around the nurses' station, you'll see female M.D.s talking with the nurses more. Patients are discussed. The nurses know more about patients' psychosocial problems, so you'll get more information. Men don't sit around and chit-chat. If you see this, it's usually single male M.D.s and young nurses sitting around and talking, but it's more flirting.

There was also recognition of the educational preparation of the nurse.

> I've learned a lot from nurses about their approaches to patient care. A physician's education is geared to what's going on inside the body and what you can use to help that body towards health. A nurse's orientation is different. The most rewarding thing about the teaching-learning transaction is you feel like a team with that woman.

There was recognition for experiential learning gains in two ways: experience over the years, and the amount of time that the nurse spent with the patient daily.

> When I was a new M.D. in the Intensive Care Unit, the nurses saved my life and taught me, because they have the experience and know when things are going sour. Now they may not know the academic or the physiology, but they've been there 10 years and are with the patient all the time. I've looked to nurses for a lot of the answers. I have a lot of respect. I speak to them on a colleague level. No matter how much learning I have, it is hard to argue with experience. I value the judgement of the nurse.

Approachability and intimidation was evident in teaching patterns. Likewise the issue of informality in teaching was evident.

> I think nurses do feel more comfortable relating to a female. They feel much freer to discuss things with you. You are a woman. They can identify with you. They question, too, to learn more.
>
> There is more informal dialogue between women due to comfortableness of approachability.

In regards to nurses teaching the physicians, one female attending at a large teaching hospital felt that there were differing reactions between men and women in their receptivity to the nurse's intervention in their learning process.

> First let's look at the M.D. being trained (i.e. resident). Here the M.D. has no experience with nurses or with doctoring, and is taught by other M.D.s (i.e. scientific things). The art of medicine however is a more subtle training and this is where nursing comes in. The nurses are expected to be caretaker of the patient. They are there day to day, hour to hour. It is her responsibility in a teaching hospital to make sure she identifies the inexperience of the young M.D. and whether this neo-doctor is performing adequately. She's covertly or overtly training the M.D. Now different personalities react to nurses in different ways. Some men don't appreciate overt intervention into their learning process and overreact to nurses teaching. They are threatened and can be aggressive. These males are insecure. The male ego. These same indiviuals regard nurses in a restrictive view. They feel nurses have limits and shouldn't go beyond that because it's a physician's domain. Others are more accepting of nurses help and almost 99.9 percent of female M.D.s are in this category. These doctors recognize the nursing contribution to their training and always keep that feeling. They realize good nurses are invaluable and carry this through their practicing years. Other doctors don't realize the contribution of nurses to their training, therefore they treat nurses as very traditional models; as women who are subservient with limited roles. There are also those few doctors who got off on the wrong foot, who don't believe nurses have an important place in the health of a patient.

One physician's feeling concerning teaching was related to the developed positive relationship between many nurses and female physicians.

> When nurses are supportive (and not all nurses are) to the female M.D., the dialogue is more personal. It is on a wider scale in terms of integrating more aspects of the patient. I feel more comfortable discussing the patient as a whole person....their emotional needs, family, their whole situation. These nurses are receptive to this.

One physician from a large, inner city, hospital felt that time was another variable that effected the quality of transactions. In the following quote, the issue of female passivity, even obsequiousness surfaces.

> The nursing staff here isn't really very receptive to having things explained to them. I like to try to explain what I'm doing. When I ask someone to do something, one of the ways I cushion that is to try and explain why it is necessary, and that might lead into a discussion about the patient. In general this is not well received because time is more important than that exchange. I don't think I've often observed female house staff trying to teach things to the nursing staff. I know some nurses who will seek me out to ask me questions, and are very interested in learning. I don't know if they ask male M.D.s as well.

The issue of sexuality was also a contributing factor in the amount of informal teaching. This will be addressed in great depth in chapter 7.

> Women are much more apt to strike up a conversation and it's not expected of us to be handsome or charming. We don't have to be anything else, except a professional person who can be respected. So the pressure is off us.

Nurses

Nurses concurred strongly with female physicians regarding the time, quantity, and quality of the teaching-learning transactions.

> The teaching and learning transaction is definitely longer and better.
>
> There is more casual teaching between female M.D.s and nurses. When you are with them on rounds, they might see something that is unique. They will say feel over here, and let the nurse examine.
>
> There is definitely more dialogue. You talk about the case. Women are much more willing to explain things to you "off the cuff." It's not unusual, if we're not busy, to sit down with a female M.D. We could just talk. They'd volunteer, "I had this really interesting case." Then they'd tell us about it. Whereas with male M.D.s, I only saw this in a couple of them. Male M.D.s are very good teachers but more in a formal setting, such as during a class. Whereas the female M.D.s would bring up interesting things in conversation. We didn't always have the luxury of having a conversation with a male M.D.
>
> The amount of teaching and learning is an individualized thing depending on personality, but I do think there tends to be a difference. Female M.D.s will communicate with you what they intend to do, plus they will listen to the observations or assessments of the nurse. They communicate better with the families. They give patients more respect and privacy (like pulling curtains, etc.), and they take the time to explain things to the patient.
>
> More informal teaching? Yes, some males are also good, but females are more approachable and relaxed about telling you things. Female M.D.s ask more questions and seek more information from nurses. Then once this gets started, the nurse feels more comfortable asking them what is this and that. Detailed and lengthy explanations follow.

In regard to the teaching process between physicians and nurses, nurses outlined some distinct differences between men and women physicians.

One time the nurses had a conference with a new M.D. director. We told him 50% of our job was teaching housestaff. He was appalled. Like saying, "What do we as nurses think we could teach the housestaff." We asked him, "Who do you think is watching these patients all day?" This doesn't occur with female M.D.s because they see you as a professional, albeit not as highly trained.

I see casual teaching by female M.D.s. The male M.D.s see this and participate, but rarely initiate it. Sometimes if we ask a male to casually teach, we may catch him "off center." We get a look of, "You don't really need to know that." One anesthesiologist, who was asked a question by a nurse said, "Well, that's above your level of learning and you don't need to know that." These are put-downs. Many don't want to share in the teaching-learning process. Where with females, they will initiate it.

Female M.D.s asked us for patient responses to things and asked our opinions. "What did the patient say?" "What do you think she (patient) needs?" "How is her pain threshhold?" Whereas with male doctors, this was not the case. They made you feel like you were overstepping your bound. They still had the handmaiden concept. Not the case with the women at all. They would solicit our input in the management of their cases....openly solicit.

What I do see is that male M.D. tends to have a God-like image of himself and it is like he thinks he is "E.F. Hutton." Therefore, he's always spewing out various things and teaching.

Sexuality also influenced teaching-learning. This is discussed further in chapter 7.

Oh yes, there is a difference between women. It goes back to being comfortable talking to them and not thinking, "Do I look good today?" You don't consider your exterior self.

Nurses felt that there was more listening in their interactions with female physicians.

I'm more comfortable talking to female M.D. They listen more.

They listen! I feel female M.D.s believe us more when we say this is so. Men want many more facts. We have to talk until we're blue in the face to convince him.

Listening resulted in mutual understanding.

> Sometimes there is less talking because there is more assumed understanding. So one can abbreviate what you say, rather than have a long drawn out conversation. This is because you feel this is somebody who understands what you are talking about already, so all that is needed is a brief outline.

One aspect noted by a nurse, and confirmed many times by other nurses, was the issue of honest versus manipulative interactions.

> I feel I can approach a female physician about a patient problem and say, "Such and such is happening or I think this may be a good idea." With males my approach is more, "It appears to be..." Then I let him say what he thinks, because nurses aren't supposed to think. We can be more upfront and honest with a female M.D.
>
> A nurse is taught in the private sector to regard the M.D. as king. Therefore for the nurse, it is the presentation that counts. You present thoughts or even challenges (disguised) so it doesn't offend the ego of the king! This is true. I think the healthiest relationship in the health care world is female M.D. to female nurse.
>
> I can be more up front with women. Can say "I think, rather than it appears." Some men feel threatened if they think you have found something before them.
>
> I would never dream of saying "it appears to be" to anyone. I have my professional pride. I am, though, more tactful with older male M.D.s simply because, I'm consciously manipulating them. I will say, "Well, don't you think it could possibly be...." or "I've noticed...." Do this much more with men than women.

One nurse talked about what she felt was a strained, even mocking, acceptance by physicians of nurses as teachers.

> I think nurses possibly envy female M.D.s, but it's not jealousy to the point where it will interfere with functioning. I've been here so long that I'm competent in what I do and end up teaching the

residents how to intubate babies. I have a class for medical students every week. Some M.D.s call me Dr._____. Some joking; others to put the screw in of, "I'm the doctor and you are still the nurse." However to some this is the only way of recognizing a nurse who is competent. So they give nurses a compliment that they feel is the ultimate compliment. I feel like the only way you can get praise is by being a physician. Like nursing is not autonomous. I taught one medical student how to suture. He is now a neuro-surgeon. When he introduces me, he says I'm the nurse who taught him to suture. He doesn't say Dr._____.

Nurses perceived their expertise and knowledge as important to the physician's training. More so, they viewed it as a responsibility.

Nurses are really intensively involved in the decision processes in ICU. "Maybe we ought to rule this out?" "Such and such presents very closely; let's check it." I feel very uncomfortable about the quality of patient care if the M.D. doesn't listen to the nurse.

One time M.D.s kept ordering an oral medication for kids. Now this medicine would gag anyone, and the kids always spit it out. No one knew how it tasted and one day we had the doctors taste it. They changed to another medicine.

Most interns are scared to death when they first step into an ICU. They will probably come in contact with nurses who have five plus years experience. They do one of two things: Some will allow reciprocal teaching where both the nurse and doctor absorb it all and you become an immediate team and patients get best care. If they write an order, the nurse may say, "Hey why don't you try this first--it's been successful in past." Then there are those who have literally said that, "I've paid a lot of money to go to medical school, I'm the doctor and I'm writing this order and you carry it out." My position then is, if I don't agree, to say, "It is my privilege to decide if I am comfortable with this order, whether you've had four years or 20 years of medical school. So if you want it, you do it." This has happened several times. Of course, lousy relationships developed.

Nurses observed female M.D.s as patient educators.

Female M.D.s want to see exactly what is going on. A lot of times she'll come in the room during the teaching process and just listen to the interaction taking place between the nurse and patient, and

> the patient's family. They will utilize this information, because a lot of times you'll see them go to someone else and use the information they have heard. Very seldom does one see men take the teaching aspect that they've seen in nursing and carry it along. They have their whole different presentation. It's much elevated and more professional; not directed to the layman.
>
> To the nurse, the female M.D. will explain things. But this is also true for the patient. They'll let the patient know before doing something like a vaginal exam. They'll explain more.

Even the presentation of patient cases may take on an informal or lay approach between women.

> I feel free to use non-professional informal (casual) language with women. To a man, I might say, "His temperature is elevated to such and such." To a woman, "He's burning up."

The nurses' perceived that the reasons for positive teaching and learning transactions were rooted in socialization.

> Women have like interests, similiar nature. Overall women talk to women more easily. Females are taught that you talk and express your emotions. I feel comfortable saying to a female M.D., "You know I'm having a hard time that this child is going to die. I'm attached." Can say this to a male and usually he'll say, "Yeah, I'm having same problem" and discussion ended. A female will talk more. There can be a more in-depth conversation even leading to suggestions. It's more than just medical. Therefore a different bond in behalf of the patient and in our interpersonal relationship.
>
> I think women were taught to share experiences. Women talk (even gossip) together. Men don't do this (not even among themselves). I see men do more bragging, i.e. not I've got this great case, but I solved this great case. Actually maybe there is more competition among male M.D.s. There is more sharing of financial things like how to set up a practice.

Following this, there was also bonding.

> For me personally, I think it is generally easier to communicate with women, so I'm excited about there being more female M.D.s.

The effects of quality teaching-learning transactions were seen in patient care.

> The physicians we work best with, their patients get the best care. This dialogue helps give us insight into what we can do for the patient, because we do have to follow their guidelines. If they don't talk to us, our hands are frequently tied, or we have to make that additional phone call, which may or may not get made, depending on if we feel the M.D. would be open to our suggestion.

Summary

Motivators, according to Hersey (1977), are satisfying factors involving feelings of achievement, professional growth, and recognition that one experiences in a job. In this chapter various motivators emerged which substantiated this position. The teaching-learning transaction was built on an educationally progressive and a managerially effective foundation, producing mutually satisfying outcomes and enhancing individual motivation.

The specific motivators which emerged included climate setting, approachability, complimentary recognition of work, solicited involvement in the process, and a willingness to physically participate. This led to enhanced teaching-learning transactions. Likewise, it created positive anticipation for future transactions. Out of this environment emerged an increased understanding and appreciation of the actual and potential contributions each had to offer. These feelings added further to a positive cyclical process.

CHAPTER 5

HOW RESPONDENTS FELT THE TEACHING-LEARNING TRANSACTION BETWEEN WOMEN ENHANCED PATIENT CARE

This chapter focuses on the benefits of an enhanced teaching-learning transaction in patient care. While most interviewed felt the actual acute medical diagnosis and treatments of male or female physicians were comparable, distinct differences were perceived in the psychosocial aspects of patient care, discharge planning, and in the amount of touching.

Psychosocial Concerns

In this chapter, interviewees differentiate between feminine and masculine characteristics. Some ascribed that feminine characteristics, such as nurturance, are perceived to be strengths, particularly in relation to women as physicians. Nurturance has not always been considered to be positive by feminists who feel it has kept women from progressing in a competitive environment. Perhaps because nurturing implies taking care of others rather than oneself, it is something many women want to alter. Yet interviewees, while not

denying that too much nurturance may not be healthy, felt that this quality could benefit patients, and possibly even the entire health care industry.

Female Physicians

Women physicians integrated the human emotional component of illness with the disease process. They wanted to be involved in the psychosocial aspects of patient care.

> When a nurse approaches a female physician regarding a patient's psychosocial problem, I think we're more empathetic. I'm interested in this and other female M.D.s I've worked with are also. Sometimes I wonder if male M.D.s allow themselves to get that involved.
>
> In my case the emotional aspects of patient care are important. I definitely see this difference between men and women. I think, when dealing with a patient, "This could be me!" I can really empathize. I've walked into the room of a woman who had a stillborn with tears in my eyes saying, "I am so sorry." I hold her hand. I want her to see that I'm upset also.
>
> Woman interns and residents that I precept are more interested in psychosocial issues. Men tend not to deal with these issues unless they're staring them in the face.

As women interviewees were describing their feelings about the psychosocial aspects of patient care, comparisons to men often emerged. These comparisons reflected different priorities of men in meeting clinical versus psychosocial needs.

> There is very much a camaraderie among "the boys" and they have got to be tough. "The Doctor" is either uninterested or doesn't want to deal with it, because he's not trained in these sorts of problems and even his own feelings have not been looked at, as far

as what he, as an M.D., can do for the whole person. Men are not that close to the "person" they are taking care of.

When a female comes in, there is this opening up. Patients have wanted someone to listen to.

The female M.D. views the patient not as an isolated entity and not as an island. She sees the problems of cooking and cleaning at home, and understands this. She empathizes with illness in the context of an important home role. For example, we had a 35 year old with breast cancer. The women were concerned with who was going to take care of the children, cook, get her to the doctor etc. Therefore we were more likely to ask each other for help with this patient. We saw the problem from a multidisciplined approach.

I think the younger male M.D., perhaps because of his exposure to the female M.D. professionally, is beginning to some degree to appreciate this. Although I've never seen it as with the females, not at the same levels. Men understand the agencies and know it has to be dealt with. They know the mechanics of getting help for patients but in terms of what this means in psychosocial terms, they prefer not to, or can't deal with this, whereas females will start with psychosocial, and then work to the mechanics of how to handle.

Female physicians observed nurses' positive reactions to, and subsequent respect for, their level of patient involvement.

If someone is hurt, depressed, or sick, I can sit down and talk to them more easily than some other M.D.s can. If nurses see you interacting with a patient in a way they think is better, they have more respect for you and are a lot happier with you as a physician.

I never did feel that nurses tested me more as to whether my orders were right, or if I made the correct judgement. I feel that they tested more to see if I was willing to become more involved with the patient.

Nurses saw also that I cared a lot for patients. They do see this, even if they don't care. Nurses do respond to the very caring doctors.

Within this milieu, nurses were encouraged to actively participate, generating an enhanced teaching and learning transaction.

> There is more discussion about the patient, the family, and how the patient feels about being ill, or whether they are depressed. Furthermore it is what are "we" going to do to make it easier to go home. Nurses frequently bring these issues up to male M.D.s, but I think more of the time than not, they are met with less discussion than if brought up to a female M.D. Probably just by being females, they are more attuned to that in the first place. The exception to this is if I'm exhausted. Then I don't really care right then.
>
> In my interactions with nurses, .I want to bring in my perceptions of what is going on. "Here's why I'm doing this; let's talk about this process or this organism." I do it all the time. I don't know if women do it more than men. I take care of some very sick patients. I feel everyone has to be together. Part of my role is to get people communicating. Maybe it is the female in me. "Let's make everything work." For patients not doing well, I'm very sensitive to family needs. I call social worker, etc. I don't know what other doctors do. Women feel a lot, even take home a lot, and worry a lot, i.e. "I feel so sorry for this family." Nurses input is so important. They are highly trained.

When female physicians were asked to articulate why they felt there was a difference among women with respect to patients' psychosocial needs, socialization processes of both men and women were discussed.

> There is more talk about patients' concerns. I see this a lot. And I think, and maybe it's my bias of being a woman, that there is more of a mutual understanding. Maybe men have this among themselves. It's just different. Maybe it's not concentrated on patients, but more business-like or matter-of-fact. But with women, it's more like we're coming from the same kind of ground or bond, and that is something that we're both more interested in than men. Perhaps.
>
> On a whole, the female M.D. and nurses are more sensitive to the patients' emotional and social background, and try to coordinate how they are going to take care of them. Female M.D.s take more time talking to people and finding out what else is bothering them. This is probably true of female health care givers in general. Women are more attuned to what they see and are more willing to deal with it than men are. We were raised to deal with people in that way.
>
> Women talk more about emotional problems. If patients are having trouble managing things when they go home, I think female M.D.s are more understanding of the things that have to be done, i.e. childcare, cleaning, fixing meals, whereas male M.D.s tend to

> think, somebody else is going to do it. They don't even think about these needs unless you point it out to them.
>
> Women on an average do think about psychosocial more. It's not absent in men; there are some that are interested. But there is more with women because of the way we are socialized. Also look at the patient population...little old ladies tend to open up more, and tell people their problems, so we will get to know more about them. Women will also sit and talk to them more. We're more patient.

Another feminine commonality, that of motherhood, also surfaced as a reason for women's involvement in, even embracement of, the emotional realm of the patient.

> Women are more involved. One young patient was dying of cancer. The women got involved: M.D., nurse, social worker. Their attitude and approach to this patient was very different than the men on the team. Everyone of us went out of our defined roles, so everyone (all of us) rubbed her back. All of us made sure she got her pain medications. She also had young children and all of us made a big push to get the kids into the hospital. We bought her flowers. She was a exceptional patient because she was so very young and there was nothing we could do for her. She died about a week after we discharged her, and we pushed to get her discharged while she was still alive. This was all the women; and we were the ones who went to the funeral, and we were the ones who got in touch with the family. In this case the male intern was setting a distance. He was very clear. I'm different because I am a parent. I have kids. So I'm nurturing anyway. They call me "momma bear" sometimes in the hospital too. Maybe it's because I have kids--maybe it's because I am a momma type person. Maybe it is because we are trained this way. Like we get dolls when we are babies. Males are better at setting up distances between themselves and patients.

While this process was perceived as being different between men and women, it was not viewed as being non-existent in males or totally existent in women.

> I think females are more empathetic than males. But here at this hospital, I have seen a lot of this in males also.

> It is easier for a female M.D. to talk about the emotional side of the patient. It is easier for a female to become involved in the whole aspect of a patient's care. We are tuned in to the emotional aspects and pay attention to this. I do know plenty of males who are caring.
>
> There are some women who are real hardnosed, who see the disease and not the patient. Also there are some men who are into the patient more than the disease (this is a minority).

There was recognition that intense involvement could take a personal, emotional toll.

> The psychosocial concern is so much true that I've had problems. I've been too involved with the nurses and their problems with the patient. With cancer patients, I've gotten very attached. I got very involved. There is much team effort in this setting.
>
> I feel things strongly; I have cried in front of patients and sometimes felt that this was inappropriate. I got to the point where I could wait until I got outside the room. Now I can get to my car. It is important to share in a patient's grief.

When the patient was a woman, feminine involvement intensified even further.

> There are more elderly women, so a lot of our patients are women. That's an interesting interaction--A nurse and a female M.D. caring for a female patient. There's a mutual understanding of how that female is going to be discharged from the hospital. We try to think about what her needs are. If she's recuperating from some illness, women understand that meals have to be cooked, or the female patient has many roles she must fulfill. So you can anticipate the kind of help that this woman is going to need until she recuperates, or doesn't recuperate.

Nurses

Concurring with female physicians, nurses felt that women were more involved in psychosocial aspects of patient care.

> There is more dialogue. If you have a patient with multiple social problems, you have to call that to the male M.D.'s attention. Whereas a female M.D. will suggest follow-up and ask the nurse about problems. She tunes into the person and will notice things like, "This patient hasn't eaten."
>
> Women can be professional and still maintain empathy.
>
> I have felt that female M.D.s are more interested in details that are further out from the patient, like social, conditions of family, and psychosocial needs. I think in general, the female M.D. and nurse's dialogue is more about the patient, especially psychosocial. Again I've had some good situations with male M.D.s.
>
> I think women have a greater sensitivity. This is also the beauty of women being physicians or being in the more esteemed professions. Women deal better with feelings and emotions, generally speaking. I think they are a lot stronger about feelings and emotions. The nurses react to this positively. There's more shared commitment. We deal with patients on whatever level they are on (use Maslow's hierarchy). I think there are men who have tapped into that feminine side of themselves, i.e. the capacity to nurture.
>
> Women talk about psychosocial much more. They take into consideration family background and what's happening at home, more so than the male M.D. If a women has post-partum depression, the male is most likely to turn it over to a social worker. It also depended a lot on how much their offices were involved, i.e. if the male M.D. had a good office nurse, she often did discharge planning rounds. The male physician himself didn't do it. But the female M.D.s do it themselves. They ask about family situations. Female M.D.s look at the whole picture; males wouldn't, didn't, and don't.
>
> If, in obstetrics, there is a problem with the baby, the female M.D. can go in there and be upset and handle it. Whereas men are still threatened by it because they don't know how they are supposed to be. It's still hard for some of them to show emotions. The male M.D. will tell patient the facts; "This is the problem and this is what we can do about it." The female M.D. will express her feelings about the horribleness of the situation, and share her feelings of sorrow. She'll deal with the emotional

> side and then move on to deal with the factual side. They allow the patient to verbalize feelings and then deal with the reality.

Nurses felt more personal rewards emanated from a team atmosphere of care and concern. Likewise, they saw that patients benefited.

> Nurses react positively to the female M.D.'s approach to the patient. I think it's great. The whole working atmosphere is more comfortable and more rewarding! I can't emphasize this enough. It makes nurses feel like they are really doing something, rather than just mechanically carrying out orders. It makes you feel like what you are doing is more caring, with more rewards from patients, because they reciprocate. People also heal faster when they feel that they are well cared for by someone really interested, who just doesn't see someone lying in a bed with an I.V. going and waiting to get better. This is what a nurse is all about. When someone isn't facing you or looking at you, while at the same time, they are telling you that they care, they are giving a mixed message. Whereas, it's a big message, if someone is leaning toward you, looking you in the eyes, and holding your hand, as opposed to standing at end of bed with a chart in their hand and writing while they are talking to you.

Female physicians followed-up on nurse queries and concerns.

> When I approach a female M.D. about psychosocial needs, she'll usually go in and talk to the patient about this.

The nurses' verified that increased patient involvement correlates directly with the amount of time spent with the patient.

> Female M.D.s spend more time with patients in trying to find out the social background. They are more interested in what really brought the patient to the hospital besides their illness. The illness is primary, but is the illness because they live alone, or is it because the family can't cope with them anymore? Male M.D.s might find out later on that patient lives alone but they don't hit on that in the beginning. Working with female M.D.s is sometimes aggravating because they take so long with the patient.

> The family was always consulted. Female M.D.s get more involved with the patients.

Nurses saw that female M.D.s related more of their own personal life to patients, hence decreasing professional and social distance.

> Female M.D.s communicate more with mothers and relate more to the sick child by relating experiences with their own children. Mothers see a doctor who knows what they are going through. The same with obstetricians. Male M.D.s are kind of more authoritarian. They are fathers too, but more, "I'm going to take care of your child for you" rather than, "We are going to get your child well." Male M.D.s are more professional. Not all female M.D.s are unlike this, but most.

Nurses observed adverse male reactions to the female physician's increased concern for psychosocial aspects of patient care.

> I have seen female M.D.s put down for bringing this up in rounds.

Nurses perceived that the results of this philosophy shared with female physicians was exemplified in their own motivation to contribute their expertise in this process.

> Male M.D.s approach things more like a cook book--following a recipe, step A,B,C... I feel I can more explain a certain situation and get more understanding from a female M.D. And they listen to me more! Yes, more quality teaching-learning transactions; more colleagueship; more camaraderie. Very discouraging to feel you've discovered a need that the patient really has, and the M.D. is not willing to listen to what you have to say.
>
> The female M.D. looks at family situations, yet they don't have the time to go to each family member. So when they present themselves to each patient, the nurse is there. She (the nurse) sees the patient and the family interaction. Only the female M.D.s take advantage of the nurses' vantage point.

> In some instances with males, nurses feel they may even be laughed at if they bring up stuff which may make them look like a "softie."
>
> The nurse is the liason between social workers and M.D.s. Yet we understand, especially in ICU, that M.D.s are stressed; they get no rest. But again, even in these situations, the women have a different sensitivity. They'll address all medical needs on rounds and the care is equal (between male and female M.D.s), but women may sense that extra something in the patient. It comes back to that mothering, nurturing sensitivity that is more female than male. So you'll see a female M.D. come back to that patient in the midst of a busy day. The nurse therefore is drawn to this M.D. for any idea and belief that she feels will be considered, even if it seems different from the basic care plan or from a certain diagnosis.

In essence, nurses felt that the female physician utilized the strengths of nursing, and realized potential contributions.

> Women M.D.s are more interested in psychosocial concerns and this makes them more interested in what the nurse has to say. They can look at the patient and realize the patient has a life besides just his disease. They ask, "How is this disease going to interfere with his life." Also they look at nurse and see how nurse fits in with the patient, and not just what the nurse is doing for the patient's disease.
>
> Quite a bit more dialogue between nurse and female M.D. because they're more receptive, willing to listen. Men even tend to make a joke of something. I mean, they will deal with it, but differently. You can't just sit down and say, "So and so's husband is obviously not interested in this baby and what are we going to do about it." He'll just say, "I think we need a social service consult." The discussion is briefer.

Nurses, like female physicians, saw the common socialization of women as contributing to this shared humanistic approach. Likewise, this similarity facilitated bonding among women.

> One of the things with female to female is that you have basic natures because you are women. Nurturing is a product of being female in our society. A lot of our interests and focus will be

> on this. Not enough to just go into a room, give the patient a good explanation, review the chart, and make sure the patient is comfortable. But it is sitting down with the patient. The nurturing side comes out--it is like that extra 5 percent. Don't attribute this to attitude (although I have seen it in men), but almost like a natural in most women. To the patient this is very important, and to me as a nurse, this makes me very drawn to work with an M.D. that shows this. Because our interest in the patient is broader than just the immediate medical problem. Like in pediatrics, it becomes the family unit as a whole, not just while they're here, but when they go home.
>
> Female M.D.s are more apt to listen. Nurses will automatically pick up on psychosocial aspects. We're trained to. Also part of our femaleness picks up on this. So I think female M.D.s, because of their femaleness, tend to listen more and are concerned about this aspect of patient care. Male M.D.s don't want to be bothered with it. It is like, "You handle it; you're the nurse," or "call social services." Maybe it's a mothering instinct.
>
> Females are more involved. Not a conscious process, but a way that they give their care. Males don't address this. It's cultural. Women are nurturers. Maybe there is just that much more nurse in every female M.D. than in male M.D.s. Maybe a caring, interested, involved person is easier for them to do. Not just someone who writes prescriptions and gives treatments; the distant care often given. Female M.D.s bring this aspect to patients as well as nurses. Women are less formidable, definitely more approachable.

Nurses felt that nurturance was exemplified in the female physician's concern for patient comfort.

> The female M.D. is more interested in the little patient comforts, not that they necessarily do it. But they will say, "Her mouth is dry. Let's do this for her mouth care." She will recommend more comfort measures, over and above medical treatment.

Nurses noticed patients' response to the female physicians' caring and concern. Patients voiced their positive feeling about women physicians and showed this by requesting referrals from nurses.

> Patient's are often afraid to ask the M.D., "What does that mean?" or "Tell me what that means in language that I can understand." The patient waits for M.D. to leave and then asks the nurse what it means. With a female M.D., patients seem more comfortable asking questions. Again, the male ego is gone, and they are looking at a woman being an equal rather than superior.
>
> A lot of women who come to me for referrals will request a female M.D. I think they are saying that they want someone who will care for them as a person.
>
> For the most part, males examine and scoot out of the room. Females have that mothering instinct which allows them to stay and talk for a while. Even their body language tends to say more of, "I care about what is happening to you." The more compassionate your M.D. is, and most females are compassionate, the more your patients feel like you care, and will come back to you more and more. Compassion is important in illness when a person is vulnerable and scared. Communication is such a big part of health care. I think women are better communicators. Law suits are brought about often by lack of communication.

To some nurses, female physicians' approaches to patient care were related to whether they were mothers. Then distinct differences were evident.

> I think it's individual, but, to a point, female M.D.s are willing to listen to the patient a little more. But as far as dealing with psychosocial or showing of emotions, I don't think they show them anymore than a male M.D. Part of this is to show they are strong, that they are the "Doctor." In teaching breast feeding, the female M.D. may talk a little more about what to do, not because they know more, especially if they haven't done it. But because they are a woman empathizing with a woman. You talk to a lot of female M.D.s and they want to breastfeed. Don't see this all the time--some of them. Most males expect a nurse to do it. Some females expect a nurse to do it. But if a female M.D. is a mother, this is different; the motherhood aspect is more of a binder.

Nurses reflected on the changes in societal attitudes over time, which they felt influenced various age groups differently. One's age is

important when assessing physician involvement in the psychosocial aspects of patient care.

> All of medicine has changed in the last few years. Society's attitude about female and male has also changed. It's becoming more acceptable for a man to show the characteristics that we don't attribute to them, i.e. compassion, warmth, etc.
>
> I have seen female M.D.s more involved with psychosocial needs. It's common that a woman will want to know specifically what is going on, and discuss this with the nurse. Probably a male M.D. would just want someone else to deal with it. But this is not across the board (can't totally generalize). Women do have more a whole patient approach and tend to be more compassionate, rather than having a facts and figures type of conditioned medicine response. Men though, through new socialization, are being allowed to express feelings of empathy that heretofore only women have been allowed to have.
>
> I've known a lot of female M.D.s who are trying to prove they are tough. I'm also noticing a new tenderness in our male M.D.s. They are younger and are getting this in medical school. Also there are more women medical school instructors. With new yuppies, it is an "in thing" to be a caring, sensitive male. Look at the new articles on fathering. Many take this and apply it professionally. So not much different in female and male, except as related to age.

Another variable pertinent to physician involvement with patients dealt with the economics of medicine.

> It used to be that psychosocial was the nurse's problem. Doctors told us to take care of it. In a way, capitalism is motivating the desire of M.D.s to participate in this more. Because people that have a good rapport with patients don't get sued as much as those that don't. Furthermore medicine is becoming more competitive, so M.D.s extend themselves more to get patients.

Discharge Planning

Discharge planning is the process whereby a patient is prepared to leave the hospital and function in his/her regular home environment with or without further assistance. Discharge planning can encompass teaching the patient how to care for his or her disease and/or prescriptions for various community services to aid in rehabilitation. This is an important process, for without it, many patients, especially those with chronic illnesses, increase their chances of returning to the hospital, often in acute stress.

Female Physicians

Female physicians' attitudes favored active versus passive involvement in discharge planning.

> Most female M.D.s will do it herself, like call Alcoholics Anonymous or write an order for the social worker. As a preceptor, I have to take many male M.D.s through the process--step A,B, etc. Women follow up. They take patient's phone number. They know more about the patient's situation, (i.e. this person doesn't have a refrigerator; this person is a homeless person). Men are less likely to know this.
>
> In discharge planning, women absolutely do more. If a patient is going home, the men don't know where he's going, or who, or what his family situation is. The women always do. More dialogue between female M.D. and nurse.
>
> My experience is that the male physician could care less about discharge planning. Nurses in public health will tell you a male M.D. doesn't utilize their services like a female M.D.; it's more business-like instead of a mutual problem-solving transaction.
>
> To a male M.D., the patient is in the hospital, he does his job, maybe a few further interactions in the office, then write it

> off. He does not want to be introduced to facilities in the community that might help. He's just plain not interested.
>
> You know that the patient still has to exist once they go out the door. I think the male end of medicine may still have that attitude "out of sight, out of mind." "If patient leaves hospital, it is out of my control." For most part more, women try to get money or social services for their patients, even if frustrating at times. They will even sit down and speak to social services about patient problems. Most social workers are women also.
>
> Women have more detailed discharge plans. They're more pertinent also to a woman patient's needs, and to accomplish them in a way that'll be dignified and really supportive. There is an understanding that getting someone in to cook meals is an important function and has implications because that patient can't physically do it. Furthermore, it can be a threat to her role in the family. I don't think a male M.D. would react the same way, or look at it this way.

Once again, feminine socialization and upbringing were suggested as prime factors which motivated their involvement.

> Female M.D.s tend to worry more about the practical things like what is this patient going to do when he/she gets out of here, and not just what their disease was that had to be taken care of while they were here. This is because women are attuned. It's their sexuality. Women are programmed to think of the practical nature of life. A woman's upbringing.

Female physicians' involvement in discharge planning led to more transactions with nurses, resulting in fuller appreciation of nurse contributions to this process on the part of M.D.s.

> I know personally that I tap into the nurse's ability to help the discharge planning process. They are the ones who see the family more than I do. They are the ones who know whether somebody is really feeding themselves or not. I got great at discharge planning, but I also recognize my limits in terms of what I know about patients, i.e. what degree of home care they need or where they live. It's easier when you recognize your limits and see what others have to contribute.

Some felt that approaches to discharge planning were not significantly different between genders, especially in stressful working environments.

> The thing about discharge planning, especially at this hospital, is that everybody has too many patients. Everybody wants everybody to go home--and to stay home and not come right back. I think the males that are good intend on getting them out and keeping them out. Don't know if I can say there is a difference between men and women. The gain is there for everybody, so everybody pushing to help patient get out.
>
> There is no big difference in discharge planning along sex lines. Men might express concern differently, i.e. vocabulary.

Nurses

Nurses felt that male physicians were oriented more to the acute and in-hospital aspects of illness.

> Male M.D.s seem to be oriented to, "See me in my office." Whereas women ask, "What are you going to do when you get home?" More aware of living situations and possibilities of doing something like transportation: "How are you going to get back and forth?" Men either expect nurse to do that or expect it to be taken care of, but don't address it themselves personally.
>
> Female physicians make a definite decision; they want planning to take place and they want to see it. They are involved in it. Where the male pretty much leaves it up to the staff on the floor and whether it gets done or not is not his primary interest. As long as the patients have their future office appointment and their instructions, they don't care how the teaching takes place. Not an attitude of not caring (in the word caring sense). "It's like your responsibility, and I expect you to take care of it. Don't bother me with it." They are concerned but it's not the same type of response that you get from the female M.D.s.
>
> So many M.D.s work in the here and now. If it's fine here, don't look beyond, i.e., if patient needs help at home. They don't see the need for this. They come in and say that a patient can go

> home tomorrow, and maybe the patient can't do it or neither can the spouse. Many M.D.s not aware of what is involved to get help. A lot of M.D.'s don't utilize nurses' knowledge. Female M.D.s, though, go that one step further and really work on those things before hand. They ask a nurse's opinion. A female M.D. definitely spends more time personally with discharge planning. She gets on the phone herself to make arrangements. The men let the nurse do it.
>
> Most male M.D.s, when you talk to them about discharge planning, are less empathetic. They kind of just want to get the patient out. I have seen a female M.D. get very involved, i.e. calling families, etc.

Socialization, innate feminine characteristics, and maternal instincts were considered motivators in nurses' analysis of women's concern for and work in discharge planning.

> Women are more empathetic. They look at the patient more as a whole rather than just what's going on at the time. They think ahead.
>
> Students are not taught about discharge planning or the psychosocial aspects of patient care in medical school, so the male M.D. doesn't learn what women innately have.
>
> I will see a greater majority of female M.D.s doing the extra mile beyond direct clinical observation than male M.D.s. Maybe this dates back to maternal instincts. The male M.D.s don't get involved this extra mile. For example, Mr. Doe (a street person) has lice. He needs somewhere to go to wash his clothes and take a a bath. More female M.D.s respond to this aspect. They give the medications, treat, and then try to get information on where he can wash clothes and take a bath. With men, I don't know if it's that they just don't think about it, or if they feel uncomfortable approaching the patient about it. I don't know which it is. If a male M.D. doesn't deal with it, the nurse usually picks it up when discharging the patient. Then she has to go back to the M.D. to ask for a referral. It might have something to do with socioeconomic disparities between many M.D.s and patients. Some respond (in dermatology), "I'll take care of the skin, you (nurse) take care of the rest of them."

The results of this concern for discharge planning were seen in better planning, better patient compliance, and better nurse/female physician communication.

> Female M.D.s will call us more readily to do more teaching prior to discharge, and to do it earlier in the hospitalization than the male M.D. Men wait until the day of discharge--always last minute.
>
> Much more collegeal with women. I do see where male M.D.s are a little intimidated with this, but they've got to look ahead because of the way things are changing. The hospital stays are shorter and the patients are sicker when they go home. They need almost as much care at home as in hospital. Maybe male M.D.s need to do more home visits.
>
> With men, it is, "See me in my office on such and such a date," rather than "Are you going to have problems with this when you get home?" Female M.D.s are interested in what kind of care is going to go on once you step out of hospital door. "Are you going to follow through with medical treatment." When you ask somebody these things, they are more inclined to do it. With men, patient may get home and have to call M.D. to find out. Whereas a lot of this territory has already been covered with female M.D.s. It's done before the patient gets away from her. She asks, "Are you going to have a problem doing this?"; rather than finding out later that there was a problem or not finding out at all because the patient never told you. The female M.D. is interested in what the nurse has to offer in discharge planning. She follows through more. Definitely...I think there is more of a feeling of concern.

Touching

The third nurse interviewed commented that she had observed female physicians actually touching their patients more. This theme was followed up in subsequent interviews.

Female Physicians

I touch a lot. It makes a big difference. In general, society brings men up not to be huggy and touchy. Some men have been able to escape that, and can hug and touch. This carries over to their patients.

Do female physicians use touch more? Absolutely. I'm always touching my patients. Definitely, women.

I have heard more and more mothers say that they want a pediatrician who touches. I would guess women to be more touchy.

Touching? Females aren't afraid to touch. Men are now doing it more; maybe learning it's okay. Also there is medical competition, and you have to touch patients if you want to keep them.

More touching? Definitely true; women are not afraid to touch people. Women do it much more easily.

Nurses

Nurses, in their observations of female physicians, felt that touching was different, significant, and an element which drew the nurses to work with women physicians.

The physicians I have the greatest respect for have that empathetic touch which I think is so important. Many women have this. I put them in great admiration, rather than just a good M.D. who knows the facts and figures and certain criteria to make diagnoses and treatments. They are an extra special person who adds touch and concern. This is what the patients need. They need to know that you really do care about them. My most respected M.D.s are women who have this quality. They are equally as competent, but the differentiating factor is their compassion. I enjoy working with them.

There is a difference in the way women react to patients. Generally men are a little bit more pulled back. Don't want to get too personally involved with the patients. They want to come in, look at the incision, take a look in chart, "You're doing fine and see you later." Whereas women are more gentle in taking off the dressing. They touch.

> There is more touching and actual hands-on contact, the reassuring type of contact. More eye contact. More physical contact. More body language that says I am interested in you; not standing up stiff, and making pronouncements. This is changing with younger males but still definitely different with women. Especially with kids: women rock, hold, reassure, caress, touch their heads, and speak in soothing voices. I don't know if cultural, but I definitely see this more.
>
> Female M.D.s seem to be gentler, kinder, and more motherly with their pediatric patients. I think women as a whole are instinctively mothering.
>
> Women physicians (and some of the men) sit on the bed, hold hands, interact more, have a calmer voice, and they spend more time than most men. The patients are more open about their problems. There is more conversation. Women don't go into a patient's room with a five minute, "This is what is happening" speech and leave, while the patient has to ask the nurse what is wrong, or for clarification.

Summary

Patients directly benefit from female physicians' and nurses' motivation to optimize the teaching-learning transaction. This chapter described the essence of this as the participants applied their established approachability with each other to the patient. This, they felt, expanded the clinical component by strengthing the humanistic element.

This also exemplified the personal powers and perceived feminine strengths of women in both professions, consequently drawing them to work more closely. They observed each other in an environment of nurturance, compassion, and sensitivity, not only in dialogue, but also in actual hands-on contact. This resulted in more team efforts and produced respect, even emulation, which subsequently reduced barriers and opened the doors for expanded future transactions.

Chapter 6

SOCIALIZATION AND BONDING

To fulfill the objectives of this research, it was important to assess perceptions on "why" there were differences in many facets of the transactions. As has been shown, the women interviewed felt that there were distinct differences between men and women regarding psychosocial aspects of patient care, discharge planning, and in the way gender similarity influenced how women could and did relate to each other. When respondents mentioned these differences, the response was always followed by the question, "Why do you think this is so." What kept surfacing over and over again, in almost every arena of discussion, were factors which reflected commonalities in the socialization processes of women, in motherhood, and even in the biology of women. Accordingly, this chapter was created as a separate entity.

The Socialization of Women

Socialization and experiences of women influenced how they viewed illness, and how they saw their role in illness.

Female Physicians

> Illness is more natural to women. Men put illness up on this scientific pedestal. Women have taken care of their sick children and have experienced childbirth...which hurts. Most male doctors probably never took care of a sick person when they were growing up. I think this commonality of a woman's view of illness strengthens the teaching and learning situations.
>
> Females have more clarity. They look at illness as a part of life. They don't have to be tied up in the scientific aspect of the whole thing.
>
> Women are more nurturing. This is a learned behavior. When a man becomes an M.D., they are dealing with illness for the first time. When my mother was sick she never asked my brother for soup. It was always the women who helped.
>
> If a male M.D.'s baby is sick, he'll say "I'm babysitting." His attitude is like he's doing a great favor for his wife. A woman will never say this.
>
> In seeing illness I'm more laid back--people get sick, they hurt, they'll get better. A lot of times guys will jump in too quickly and order all this and that, when maybe they are just uncomfortable seeing illness.
>
> In my family it was me who took care of my sick grandmother while my brothers were out playing football.
>
> Nowhere along the line can one deprive women of some of the maternal instincts they have. And no matter how much a woman might try to ignore the maternal instincts themselves, they are hard put to do it. But this is not to say men can't be tender too.

Their emotional involvement with illness was another issue often ascribed to how women were raised.

> We are different. Women are allowed to be more emotionally involved. This is not just expressed in, for example, crying if a patient dies. It's that I think women have a better understanding of what somebody feels. It is not that you take this and get "silly" with it; it's that you appreciate what someone feels...empathy. I understand it and try to deal with it. This doesn't mean women necessarily deal with it any better, but at least they have a better understanding and don't try to ignore it,

> which I do see some of my male colleagues doing. Again this is a function of the cradle and how you are brought up.

Learned behaviors for women included the ability to "pick up" on emotional cues.

> The difference between male and female is variable, but I think it is skewed towards the female. They are more oriented to the psychosocial aspects of people. It's part of our socialization process. Women are socialized and get positive feedback from the beginning for responding to people's emotional cues. Men are not quite as reinforced for this type of behavior. I think that women have an intuition which includes finely combed abilities at picking up nuances of behavior. I mean slight looks and subtle body language. Most women can read the meaning of this behavior. Most men might not even see the behavior in the first place. Women are very, very tuned into behavior in very minute ways. And this goes on to understanding people in their context, and we do it because it is easier for us. It comes easier because we have learned it. And I don't think that most men have had this type of experience. How does this affect the relationship with nurses? It really does in that when nurses approach a female M.D., these things come out.

The biology of the female was a factor which helped women relate to patients in a different way.

> I'd hate to say that a male M.D. is deficient because he was never exposed to or took care of a sick person before he got out of medical school. But in a way, I think that women are more accustomed to paying attention to people that have aches and pains, because we females have monthly aches and pains. And men have never had to deal with this. So it's very difficult for them to imagine pain. I never understood when my sister got cramps why she went to bed...until my first period. I was sorry I hadn't been more understanding of my sister. This kind of thing men don't understand. I think some of the male M.D.s are receptive to pain. If they see enough of it, I think it begins to sink in.
>
> Women live with more discomfort as a part of being female. Males usually only experience pain as an athlete or in trauma. Pain is more a part of a woman's life. So female M.D.s and nurses are more sensitive to pain on one hand, but also they are more realistic about it, i.e. how much someone should complain about

> it. Because we know how bad pain can be and what is not that bad. It's easier then for a female M.D. to talk to a nurse about pain because of their common association or backdrop against which to measure pain. Whereas a male might be more callous because he doesn't know. Likewise a women may also have a better feel for distinguishing hysteria from pain.

The feminine socialization process, which produced the strong nurturing characteristics, led to characteristics which were perceived as limitations or weaknesses. Learning to become an assertive leader, a perceived problem for some female M.D.s, is an example.

> When a M.D. first starts off, the nurses always know more than the intern female and male (and they like to let you know). But the male can carry off better the command or leadership role, generally speaking, because they are used to it. Female M.D.s feel this right away and try to figure out how to tell people what to do without them getting mad at you, because they automatically know this is not expected to come from the women. When I was a medical student, I never had been in a medical setting, and I think it's easier for a nurse to make the female M.D. feel bad about what she doesn't know. Female M.D.s have to learn how not to antagonize nurses and to get them to teach you. I need practice in learning how to deal with people. If I see passive-aggressive behavior, I want to be one-on-one with that person. "What's wrong? Are you mad? Did I do something?" Then if it doesn't change, I go to her superior.
>
> Female M.D.s are having a harder time being in charge. They have to be careful in expressing anger because they are not used to it, and it's not as accepted. Females are expected to be a certain way. Females have to learn how to be assertive without being offensive. This takes practice. I want to have people like me so I try hard to learn how to deal with interpersonal relations. I don't want to come across as a commanding-type or in a proselytizing way. Yet I'm amazed at how things can be misunderstood or taken personally. Males have already been in these positions and intuitively have been around. But the female M.D.s are having to switch roles as far as giving orders and being the superior.

There was recognition that too much nurturance or emotional involvement could detract from clinical effectiveness.

> Women can't let emotional aspects of patient care "muddy up" the clinical components of patient care. We can be distracted by emotions and not see what is clinically there because we're so into nurturing. We may get into, "How are you doing" but this is not as authoritarian as saying, "Well, did you take your medication today?" This may make the female M.D. a bit less effective.

Nurses

Nurses' perceptions were similar to those of female physicians; feminine socialization taught women to look at and participate in illness differently.

> Women are more sensitive, perceptive, and have the "6th sense." I think women understand women better. This is a different make-up than men.
>
> The female is taught from an early age to care for others. It's ingrained in some of us, so it's more natural to deal with all aspects of an illness. In medical school it's probably much more scientific than humanistic. So men don't learn what women have already been taught.
>
> The key to why women are able to relate, and why they want interpersonal relationships is because of their training, upbringing, and their view of illness. Women tend to have a softness about them as well, even though they've been in medicine for a long time. They never lose that softness. "What if this were in my family?" "What if this were a friend of mine?" With men, it's "I can't let my softness show." "I have to maintain a leadership role."

Nurses recognized that although they were expected to show emotion, men had been socialized not to.

> Women are definitely more compassionate. A man has to be a man. No crying. No show of emotion. Females are different; they are allowed to show emotions.

> Females are more receptive, more interested in emotions as part of the total patient, rather than just physical problems. It is easier for women to deal with it (emotional). If there is a problem with a baby, a woman can go in there and be upset, and handle it, and not walk away from it. Whereas men are still threatened by it, because they don't know how they are supposed to be. It's still hard for some of them to show emotions. Younger men M.D.s are better at this than older men but it's still different from women. Men tell patients the facts; "This is the problem and this is what we can do about it." With women, it's, "Gosh...This is really horrible--I'm so sorry." They deal with the emotional side and then move on to the deal with factual aspect. They allow the patient to verbalize their feelings and then deal with the reality. Men just deal with the reality...don't want all the tears. They'll listen to it, but are uncomfortable.

Feminine integration of certain male characteristics was viewed as helpful for women seeking achievement.

> I think it goes back to the way women are brought up. More nurturing/more caring. Not that men are necessarily not, but there is a difference. There is a difference in socialization. You do, however, see definite tendencies in female M.D.s that helped them get to where they are: strong, very capable, and having somewhat male characteristics.

The effects of social conditioning could not be segregated from professionalism.

> I think there is a difference in the way female nurses respond to female M.D.s versus male M.D.s. This goes back to societal conditioning. For both women and man, this is hard to forget, or to leave behind when you are in work setting.

The experience of menstrual and birthing pain, or illness was considered by nurses to be a positive influence on their ability to serve as caregivers.

> For a woman, to be a good nurse or M.D., she has to have had the experience of illness, childbirth, etc. If an M.D. or anybody has experienced loss or illness, they are much better with patients.
>
> Men can get real cold with people about pain. Women tend to be more sympathetic and empathetic.
>
> Men forget that gynecological exams are done in a dehumanizing position. Just a matter of fact attitude...forget the sheet.

Since women perceived illness and pain to be more natural, they were better able to accept death.

> I very much agree that illness is more natural to women. Women perceive tension or perceive pathos in a situation, and work to alleviate. They are also less scared of it, i.e. not as afraid to show emotion. For this reason alone they deal with families better. And women deal with death better. If I'm working with a female M.D., we can talk about a no code (no life-saving extremes) on a patient. They accept death much better than male M.D.s. Male M.D.s see it as a personal or professional defeat...Not categorically, but a lot of them. Few female M.D.s interpret death as a personal failure of their own. What this means to a nurse is that it's far easier to talk to a female resident about approaching a male M.D. about a no code situation. They make persuasive arguments to the men.

The Colleagueship and Bonding of Women

In recognizing each other as women, a certain bonding ensued. Some of this was because of shared socialization patterns, and some was because of mutual reactions to discrimination towards women in our society.

Female Physicians

I am aware of myself as a woman. I do feel a sense of sisterhood. And I never thought this when I was in training. I never thought that I was aware of myself as a woman. I thought that I was a person, but not different from a male doctor in anyway. But I do think those things, especially when I think about my expectations of women. It is a sense of bond with nurses. Not so much because they are nurses, but because they are women.

In the teaching-learning transaction, I think there is kind of a sisterhood. Only recently could you articulate it, but I think we've always been rooting for each other. Secretly before, now it's fashionable. The most rewarding thing about the teaching-learning transaction is you feel like a team with that woman.

I think there is a tighter bond between female M.D.s and female nurses, and medicine is going to change from this. Because nurses (and my mom is a nurse), who are in their field because they love it, and not just as a way station for something else, can appreciate what another female has gone through to get to the point where she is. The reception most nurses get from male M.D.s, I think, is one of, "I'm the superior" and "You are the subordinate." "I have a role and this is the way it is." Female M.D.s for the most part, and there are always exceptions, are less apt to say, "I am superior," and this makes for a tighter bond and a better relationship, with more approachability. Nurses will tell us things they would never tell anybody else, hence we have a much better rapport. If a nurse comes up to me to say something is not right (even if she doesn't know what), I pay attention to it because I have had similar feelings. It's not the lab or x-ray reports, but a "6th sense" of something not being right. The best situation is dealing with a terminal patient who is going to die. Here there is a bond with nurses, where you try to make the patient more comfortable. This brings out the best in everybody. A real team; nurses making suggestions and even asking the M.D. to try things to aid the patient's comfort. Nurses more open to the female M.D. about families of patient. They will talk to the men about it also, but I think there is more assurance that it'll get followed up by the female. There is colleagueship, camaraderie, and empathy. We've all gone through our own struggles. We know what we went through. Anybody who is serious about what they do has thought about this. Many nurses like nursing. We've (female M.D.s and female nurses) have both achieved in our own way.

One female physician, noting the negative, often discriminatory, ways women were perceived in our society, felt that working together helped dispel the myths, while fostering bonds.

> I enjoy working with women...to experience their intelligence and creativity. I came from a traditional family where I got messages from my father that women were dumb, chit-chatting, etc. As I would work with women in crisis situations, or late at night when we're both tired, or in solving a big problem, these were the kinds of times I experienced women in a positive fashion. As I'm working on viewing myself more positively as a woman, I'm interested in women's strengths and watching them work. My first glimpses into this were with nurses.
>
> I've had nurses say that they were really proud of me and pleased to see a woman in my position.
>
> It is much more fun, women working with women.
>
> Most nurses say, "Oh God, you made it" because medicine is still a man's world.

Female physicians were cognizant of the impact of their professional variance from the traditional roles of women, and of nurses.

> In times past, one knew that being a nurse was supposed to be what women were supposed to do. With this in mind, you are not always sure how nurses will react to you as a female M.D. M.D.s have always given orders, but it's been male to female. Now it's female to female and this is different. We don't want female nurses to feel intimidated or feel inferior. So female M.D. does go out of her way to relax the climate. But I do see some young males doing this also.

Female physicians found that nurses supported them in the face of male adversity.

> Nurses were supportive to female residents if they got yelled at by a male M.D., and they were quick to cut down a male M.D.: "Oh he's a jerk!" So a female M.D. who alienates nurses cuts herself

> off from support. There is a whole group of nurses that are very supportive to you; "We are real proud of you, go on."

Female physicians spoke of their desire to assist nurses in their relationships with male physicians.

> If we could only do something to help nurses with the men, because we've certainly not helped ourselves a whole lot. We need to teach men about this.

Relating to nurses on an equal level epitomized the aspirations to change traditional doctor/nurse barriers.

> Female physicians go the extra step to not create a subservient climate. For most part my relating to nurses is on an equal basis. I've contributed 50 percent or more to seeing that this was sensed by the nurse. I was relating to them that, "We're equal here; let's see how the patient is doing." I feel when relating with nurses that I would treat them with respect; that there aren't any hidden agendas.

One physician spoke of her enthusiasm to actively encourage transactions with nurses.

> I am real sensitive to the degree of directedness of a nurse, or on how passive the nurse seemed. If one seemed to have a curiosity or desire to share, I was always happy to hear what she had to say. We'd share ideas. I sensed my conscious need to reach a nurse on a woman-to-woman level.

Some behaviors directed toward men were almost reactionary to past male authoritarian practices. A sense of pride followed some women's attempts to change these practices.

> This one female M.D. surgeon didn't dump on nurses but on other male M.D.s. You've heard the saying, "Shit rolls down hill", meaning a person lower on the organizational ladder gets the scut work. Well this female M.D. tossed it right back. She didn't take their shit, and there was a lot of cheering going on.

Black women felt that racial similarity produced an even more significant bond than gender.

> To the black female M.D., black nurses are real proud of them. Race transcended sex. There was incredible support.

Female physicians felt that female bonding and nurturance were qualitatively different after one experienced motherhood.

> It is different before motherhood and after motherhood. This is an overwhelming shared experience of not just having the kid, but of pregnancy, and working. So when you see a woman in her first trimester, you understand how tired she must be. This is a sisterhood feeling. Furthermore after the kid is born, you are torn between the kid at home with a fever and having to be at work, because women have the ultimate responsibility. We often reach out to each other in understanding these struggles.
>
> Motherhood does increase female bonding. The relationship between me as a female M.D., taking care of sick children, is different since I've had children. I find a certain amount of mothering even in adult friendships. I'm much more sensitive. This same thing can happen for men as fathers...if they have the chance to "mother" as fathers.
>
> Motherhood: This is altogether a different bond. The feeling and the caring that is there one can only know if she is a mother.
>
> One difference between a resident and practicing pediatrician is that residents tend not to have children. Once a pediatrician becomes a parent, they become a different pediatrician.
>
> I am a woman. I went through pregnancy. Nurses ask for my opinions of their pregnancy. Nurses talk to me more about being a mother (and being a working mother).
>
> Motherhood? Certainly true; I have kids. It does make a difference. I was an older student in medical school and had

> kids. Most of my female counterparts weren't married yet. I do think the older student has a lot more to offer patients because they've had these experiences. Yet the fast track to get into medical school is all science, which I feel is wrong. I think pre-med should be philosophy and history too. The older student has lived and knows what it's like to have conflicts, and relationships, and life. A young caring M.D. will bring these life experiences, as they have them, to patient care. So maybe it's a function of age rather than gender. I don't think a young M.D. knows what the patient is saying really. I mean, they listen but they don't hear, because they don't have that personal experience to say, "I know what that feels like," and "I know what they're saying." And my overall sense is that women, even without those experiences, are more comfortable talking about death to a dying patient, or helping family members. They are less afraid of sharing and talking up front about their fears. A big aspect of illness is the emotional one. Mothering, nurturing, and the caring role is so much a part of the female psyche. Therefore it's natural to carry this over into patient care.

The concept of "mothering", when analyzed, included doing certain tasks for the benefit of others.

> Mothering tasks include making beds, giving baths, and taking care of hygiene.

It followed then, that mothering instincts and experiences carried over into patient care.

> Women do look at illness as natural. This emanates in their whole attitude, because in growing up as a sibling, they took care of them more often. With their own children, they take care of them more often. I think this strengthens your bonds with patients.

The results of bonding reinforced colleageality, and quality transactions.

> Nurses are not afraid to ask me a question, even if it's not about my patient. Ask me medical questions, which leads to teaching. "What do I need to know about..." And they don't feel like it's a silly question.
>
> Also difference because a nurse feels more comfortable talking to a female M.D. More a camaraderie and they can more openly discuss things with female M.D.
>
> I have always viewed nurses in a colleageal fashion.

Female physicians sometimes perceived, however, that friendlinesss with nurses was as a product of necessity as much as a function of bonding. This will be discussed in depth in chapter 7.

> I think, as a female M.D., you do have a greater stake at making the nurse your friend than the male physician does, because you're going to get a lot further that way than by being authoritarian. Men can get away with that--nurses may not like it, but that kind of behavior is a lot more acceptable coming from a man than a woman.

Some women did not meet the expectations for bonding and sisterhood. This will be discussed further in Chapter 8.

> There is a big range of approaches that nurses take with me. There are nurses who really bend over backwards to be supportive, and helpful, and discuss patient, and say how happy they are to see female M.D.s in the field. They are overly demonstrative. Then there's the woman who, I feel, acts like she has a bone to pick with me, in ways such as being very cold in her approach, competitive, trying to catch me in missing out on something. I get nervous because I feel some are waiting for me to make a mistake.
>
> I think (and I don't know if it's because I'm a female or the person I am), that I have more a sense of colleagueship with nurses than a male M.D. might. He might see himself as supervisory. Men, I think, are very much more aware of hierarchy, positions, and that sort of thing than I am. Now I know plenty of females who are equally aware of status.

Nurses

Nurses sensed that sisterhood existed not only in their feelings toward female physicians, but in female physicians' feelings toward them as well.

> I'm a real pro-woman, and if I meet a woman, I want to feel a sense of sisterhood. Entirely different with a male. Commonality of "womanness" runs deep.
>
> There really is that team spirit with women. In obstetrics, a lot of these women M.D.s have never given birth and most of the nurses have. They wanted our input because we knew what that patient was experiencing to some extent, and the female M.D., at that point, did not. They relied heavily on us. It was a bond...a team effort. The focal point was the patient and whatever it took to get the best end results for that patient was what we did.
>
> As a head nurse, I could approach the male physicians differently because I had the status. My staff were still in the proving stage to the male M.D. But with the female, they (staff) didn't have to do that. They were female first and they acted on that basis. There is a sense of bonding.

Nurses reiterated that they often provided extra support to women physicians and their learning process.

> I see female surgeons as softer, easier to work with. There is more of a flow between them and nurses. They will lean on scrub nurses if they are insecure or new. They are willing to listen. There was one woman gynecologist who was unsure of herself. Well, the nurses scheduled in the best scrub nurses for her surgeries, so they could help teach her.

Much of the pride that nurses exbibited toward female doctors emanated from nurses' understanding of doctors' struggles and sacrifices.

I do respect a female M.D. I know the hard work and sacrifices it takes. And the female M.D.s don't have a wife at home.

I'm proud of them and glad to have them be M.D.s. I know how hard they had to work to get there.

First I have a real positive attitude about female M.D.s. I think it's great that they are doing it and I know I communicate this. I do this deliberately because I'm aware that attitude has a lot to do with how people communicate with you. I think it's neat that they are M.D.s.

The female M.D. has had it tough to get where she is. Because they are a female, they have had to work harder at what they are doing. The competition and the pressure is so tremendous just to get what they want. They really have to be sincere and really want to be a M.D. to put up with this strain.

I see a female M.D. as one who has to work harder. She is the doctor doing more decision making. And nurses are more comfortable with her. But a female M.D. might feel a little uncomfortable in her role because she has to work harder at what she is doing, not just with nurses but with other M.D.s as well--To establish herself as not just a nurse playing doctor.

Support increased when female M.D.s were treated negatively by male M.D.s.

Nurses resent seeing female M.D.s treated in a negative way by male M.D.s. Nurses, too, have to prove themselves so they see this as a similarity between women in both professions.

Nurses sensed that the role of being a woman in medicine sometimes influenced female doctors' willingness to show vulnerability and openness to seek help.

I'm not sure most female M.D.s show their vulnerability. They are still afraid they might get knocked down if they do. A lot of them might nonverbally say, "I'm up for suggestions but I can't tell you this because I'm afraid to."

When working with residents, I know they feel the pressure. When men are approached by a nurse about a patient matter, they seem to

> come out more direct, i.e. this is so. Women hold back more. They want to be sure they are right. They feel the pressure from the "big guns," i.e. the male dominated profession. So they feel what they say has to be right. During grand rounds, I see female M.D.s set back a little, while males chat right away. Haven't met one woman yet who has dominated the picture. I've not seen them put down, but they are not given the space.

Nurses saw the female physician as a role model.

> I've also seen when nurses, in dealing with the female M.D., have become bolder in dealing with male M.D., and have overstepped that boundary of, "I physician, you nurse."
>
> One female M.D. had to fight for everything in her program. I think most females are brought up to be subservient or obedient. This one typical female M.D. showed us just the opposite of that. She was very assertive. She showed me that she had the stamina and will-power to balk. So I don't know if it's so much how we are raised, as an assertiveness within us wanting to come out. And I think there is a lot of females who have that ability. We see women acting in different ways now.
>
> You develop a colleagueship with women M.D.s and after you develop it with them, you look for it in other males. A few female M.D.s here have that quality, and when you recognize it, you tend to think, "Well that's a physician I would go to or recommend to others." So once you recognize the quality in someone, you look for it in all the other M.D.s you're working with.

Nurses recognized that feminine characteristics of female physicians were positive and contributed to health care.

> The female M.D. is taking the strengths of femininity, like nurturance, and bringing it to a powerful profession.

Bonding also led to encouragement to pursue career advancement.

> Female M.D.s are in a new territory. And a lot of them are encouraging nurses to go ahead and go farther with their education. This is a positive, "Go for it." "I did it, so can

you." "Take it as far as you can." It's not, "I did it, you can't."

Bonding of women was for some a reaction to negative experiences with men, even in childhood.

On a whole, I tend to be more comfortable around females, probably more because of my background. My father was very authoritarian (in military). I was brought up with him as the discipliner. So I feel comfortable with a female, that she'll not downgrade me or something.

I see the transaction with women physicians on more an even keel. Female M.D.s treat me more like I have sense. With female M.D.s, I feel it is more of a professional to professional type talk. For the most part with the male M.D.s, with exceptions, they sort of talk and you are supposed to catch what they say. They treat you like a dumby if you don't.

If a nurse questions a male M.D., you have to be very tactful. Don't want him to raise his hairs up. Personally I feel tactfulness should be in all communications with M.D.s, just as I would expect them to be tactful when questioning nurses. But a male M.D. might act like, "How dare you? Do it because I said so." A female M.D. utilizes time to explain why she has done something.

Like the female physicians, nurses felt that bonding increased the capacities of their teaching-learning transactions.

Female physicians treat nurses as equals. Except for one or two, female M.D.s don't hesitate to ask your opinion. Most female M.D.s are more rececptive.

Female M.D.s are willing to work with nurses more and because of this, nurses seem to do a better, more thorough job. Not that you sacrifice better care on other people's patients but there does seem to be a better understanding.

I want to know the doctor's opinion on what she notices about the patient, either visually, or confidences the patient has told her. Also if the female M.D. sees something, I feel she will go to nurse and say, "What do you think about it?"

Summary

When these women verbalized what they felt were the positive characteristics of female-female teaching-learning transactions, their reasons revolved around their socialization, biological patterns, shared experiences, and rebellion at negative stereotyping. Commonalities in socialization produced two bonding effects. The first was a positive view of certain qualities of femaleness. Common characteristics such as nurturance, compassion, sensitivity to the needs of others, understanding, and emotional intuitiveness were frequently identified as being reasons for expanded teaching-learning transactions. Furthermore, they felt that this had been applied to caring for ill relatives even in early childhood experiences.

Similarly, respondents reacted to negative stereotyping, such as women being "emotional" or "unable to make up their minds." This, coupled with their reflection of past and previous women's roles and rights, created more mutual support and sometimes reactive condemnation of men. The women studied here viewed themselves as a minority. Therefore, a camaraderie emerged from the presence of mutual struggles.

Further bonding derived from biological similarities, particularly relating to menstrual, childbirthing pain, and pregnancy. This led them to focus on perhaps the strongest bond of all-- motherhood, which they viewed as the ultimate experience shared among women.

CHAPTER 7

THE ISSUE OF SEXUALITY

Gender differences or similarities could not be ignored in this research. Sexuality, therefore, became a key theme, affecting directly or indirectly almost every aspect of the teaching-learning transaction. Sexuality was apparent in communication processes, in reactions to stress, in sexual attractiveness, in sexual innuendoes, even discrimination, and in all forms of power whether already possessed, struggled for, or manipulated.

This chapter will look at sexuality from the standpoint of four major categories:

1. Humor and flirtation;
2. Apology;
3. The traditional male physician image;
4. The relationship of female and male physicians.

Humor and Flirtation

The differences in the amount, type, and reasons for humor in transactions among women and between men and women, are related to

sexuality. The first comment, made by a female physician, regarding this issue follows.

> I see a lot more kidding and joking between a male M.D. and nurse. This doesn't occur between the female M.D. and nurse. I think this is very much an underlying sexual phenomenon. Since this doesn't exist between the female M.D. and nurse, the female M.D. has to find firm ground to work on, and they have to be on a basis of mutual respect. Actually this may be healthier than the other with its sexual connotations.

It became evident in follow-up interviews with female physicians, that humor was part of sexual flirtation, tension release, and games.

Female Physicians

> I see nurses respond in a different fashion to male M.D.s. There is a lot more kidding and joking, and stuff that goes on that is very traditional between nurses and male M.D.s. This doesn't occur with female M.D.s. The female M.D. feels somewhat set apart.
>
> Humor? Yes, much more between male M.D.s and nurses. You can't flirt with a female M.D. The female M.D. and nurse have a more professional relationship.
>
> There are sexual overtones within the humor.
>
> There is more teasing with men--definite different ways of interacting. The men interact with the women as someone you flirt with but don't really get to know. You have fun for the moment and leave. It's not necessarily to get the nurse to do more.
>
> It would be nice if we could have a joking relationship without having it be based on the underlying sexual tension or whatever.
>
> There's more camaraderie among women. I've only had one negative experience. All others (nurses and other female M.D.s) are warm, nurturing, friendly. It's different with men. The friendliness is more sexual.

One respondent noted that some women felt uncomfortable projecting a sense of humor.

> The fact that there is more humor between men and women is absolutely true. Much less with women unless a woman is very friendly and outgoing. With men, they don't have to work at it as hard.
>
> In many ways, this does make the work much easier because you can have some fun doing it.

Flirtation, evident in humor and congeniality, derived from a desire to impress.

> Between women, flirtation is not an issue, so there is not that feeling that you have to make yourself look good (brain and beauty) in order to be accepted. A woman is going to accept or not accept another woman. But between men and women, there is a greater importance at not looking bad, and not looking stupid.
>
> Single men and nurses are congenial in passing. They are potential sweeties.

Flirtation between male physicians and nurses had, as an underlying motive, a desire to achieve patient care goals.

> There is much more manipulation between male M.D.s and nurses (especially here). Men seduce the nurses into doing things for them.
>
> Nurses use flirting as a way of considering someone their friend. If they need an I.V. started, they will ask someone with whom they can be flirtatious, and kid with, as opposed to a threatening M.D. The flirtatiousness or the sexual thing is important.
>
> Nurses use their sexuality with the male M.D.s. They can't with women. What kind of sexuality do they use? Hugging, caressing body language, the way they look at a person, and in making more social conversation. Men like this, and play along with it too. Manipulation? Yes, it serves for an ultimate goal, i.e. to write

an order. For a female M.D., there is more explanation of rationale.

Nurses seek out M.D.s they are comfortable with, like men they can be flirtatious with, and ask them to do extra.

I think of the fact that doctors have to seduce nurses in one way or another. I've learned that a nurse can ruin you. And nurses know that they have that power to undermine a doctor. There may be something in the gestalt of training that makes M.D.s know this. I am reminded of a male M.D. who had accused nurses at one hospital of being so picky and so careful that they were driving M.D.s crazy. They would call them all night long about a tiny little rise in temperature. When mentioning this complaint to another male M.D., he said, "I don't have any trouble with those nurses. I can get anything I want out of those nurses!" He had made it his business to relate to nurses in a semi-seductive way. It was manipulative and he was very proud of it and I don't fault him, because he had a better relationship. Actually, I fault both the nurses and him (the manipulator and manipulatee).

There is poor morale here with nurses. I have seen better morale in other hospitals where M.D.s and nurses communicated better. But here, the level of flirtation is also higher. Large amounts of energy are spent by M.D.s and nurses in looking good for each other, and that might mean just performing your duties very well. The flirtation might just be excellent service. Definitely sexual intrigue to this atmosphere.

Most males know that if they compliment a nurse or go out of their way to be a little flirtatious, they'll get more back in return.

Flirtation was often age or time limited, even seasonal. Furthermore, the status of a social relationship between two individuals could influence professional transactions.

With a male M.D. and nurse, it might be difficult to overstep that boundary of professionalism: to have an affair, end it, then still have to work with each other.

Flirtation is time limited. If a male M.D. and nurse find out on a date that it's not going to work, then their consequent professional relationship changes. Or once an M.D. and a nurse are dating, the flirtatious relationships with other nurses stops. Flirting is there between males and females, but I'm not sure to what degree. I know it's limited. Those nurses over 40 aren't really interested in the new young interns coming out.

> They are playing games, but most try not to let it get out of hand. They don't want rumors. If two people are not dating anymore, they still have to work with one another. This is a sticky situation.
>
> I have to break it down into different stages. When I was a medical student, I was always struck by how the nurses perceived the male medical student. Nurses were more attentive, i.e. in getting things for them, "Let me get this for you Doctor." Also they went to the bedside with them. For me they'd say, "OK, the stuff is over there and you know how to do it." I thought this was different. This is sexual; it's a potential emotional relationship. I didn't notice this as much when I got to be an intern; maybe I just ignored it, or got tough skinned to it. It's seasonal too--when July comes around with a new crop of individuals, everybody is interested in what is coming up and who they are. And the hospital is made up of a lot of females (technicians, secretaries, nurses). But this doesn't last long. Once the newness disappears, the separation (distinction) between female and male becomes less and there is more emphasis on person. The more advanced I get, the gender plays less and less.

While relationships between men and women may change in relation to the sexual issue, women felt their relationships were relatively stable in this aspect.

> The woman M.D. explains a lot to nurses. For example, if a new development happens in a case when they (nurses) were off-duty. This is probably different with males, especially if young and eligible. They may get an initial better response with a lot of questions from especially young females (because of element of flirtation). Then this can backfire, because soon it's decided that they are not a datable pair, or even that he or she is a jerk. Therefore, the female M.D. will still have the same relationship, while with men this may change.
>
> With men and women, the sexual issue is always there and you have to rise above it or work through it. With women, it's not there.

Female physicians were aware of the "datability scene" among men and women of all professions. Female/male attractions were, of course, considered normal. However, to the extent that they impaired communications between people who were not potential sexual prospects,

there was resentment. This is reflected among female physicians who observed nurses overtly catering to their male colleagues.

> This burns me up. In the ER some nurses, especially young, cute, single ones, could give two craps about helping me out when things are going busy. But then I'd look over and see a young, single guy and they'd have I.V.s, etc. in his patients. And then they would come to me to tell me I needed to draw four blood gases. To help me out is not going to do them any good. I'm not going to ask them out on a date. Working with me has no ulterior motive because I'm not giving them anything back, especially sexually.
>
> This one male M.D. is always flirting with the nurses. He got much attention and said things only once. They never heard me the first time.
>
> If I walk on unit with a young, attractive male M.D., forget it. Raw meat! One nurse even pumped me for information on a particular male intern. Nurses will ask us about other male M.D.s because they know we work with them. "Is so and so married?" A girl talk situation.

Besides flirtation between men and women directed toward social gains, female physicians felt that the difference in nurse behaviors towards them stemmed from the different way women view and react to males in our society.

> Some of the nurses in the unit are difficult for me to approach and easier for men to approach. Nurses do somehow give females a harder time than males. I know that flirtation is behind this, as well as males being an authority figure.
>
> Usually there is a pretty distinct difference between the way female M.D.s and female nurses interact as opposed to how female nurses and male M.D.s interact. Specifically, there is the flirtatious element between men and women. By and large, it is easier for male M.D.s to get nurses to do things than it is for female M.D.s. This is because of flirtatiousness and authority. I see this even in nurses I consider very good and very professional. I see things get done faster if a man asks as opposed to a woman. If a patient's blood pressure is needed, for a male the cuff appears and for a female it doesn't. Furthermore, some male house-staff have nurses which spontaneously bring in food when they are on-call at night. I don't know of any nurses that

> bring in food for female M.D.s. And these are not necessarily special relationships, but just solicitation.

Female physicians observed humor among themselves and nurses, albeit for different reasons.

> One does see humor among the female M.D. and nurse who know each other. They kid around all the time. But it is a friendship kind of humor and not that you are going to get something from these individuals.
>
> The humor between men and women does have sexual connotations, like "Hey baby, How you doing?", or putting an arm around them. But once I get to know someone, I like to use humor. But the joking is more situational...trying to find humor in our work. We laugh at humorous situations. I don't usually approach someone with a funny joke. My initial interaction is not a joke.

The issue of quantity and type of humor was reflected in gender expectations.

> I also find that nurses, at least on the surface, are accepting of jokes from men that they would never accept from a woman. (Any type of joke). They almost expect it from a man. I don't think that their standards are very high in terms of their expectations of respect from men. But I think their expectations of respect from women are.

Mothering, regarded as positive in dealing with the patient, was seen in professional doctor/nurse relations as showing favoritism to the men.

> With the older female nurse, there is not so much flirtation as a mothering role. Again they are nice to men and bring them food. They make sure that they get Thanksgiving dinner, the little things. I don't think they look out for the females like this.

Sexuality was also identified as a factor which reduced the teaching-learning transactions between male physicians and nurses.

> Men may be uncomfortable. Some men have trouble being friendly with women because there is always underlying sexual energy. So they are not as comfortable interacting on a friendly level, and are therefore more abrupt. And if friendly, this is possibly misconstrued.

Within this sexual framework, female M.D.s, because of their status, regarded potential sexual relationships with male M.D.s as being unlikely, even nonexistent.

> Many male M.D.s are not attracted to the woman M.D. because they are seen as competition. The nurse is not.

Sometimes female M.D.s were first apprised of the extent of nurse/doctor flirtations by their male M.D. colleagues.

> One male resident once remarked about the amount of flirtation actually going on. He said it goes on all the time; it's phenomenal. As a married woman, I was oblivious to this. Then I actually sensed it in the operating room...everybody standing together for hours.

When sexual flirtation was viewed as causing adverse behaviors and manipulation, women reflected on the absence of this in their relations to each other.

> Some older nurses are very thankful to have female M.D.s around. They are tired of the game. They are tired of the submission. None of this underlying crap is going on with women.

Women physicians voiced their awareness of preferential treatment by nurses toward men.

> I've said kiddingly to nurses, "If I were a man, you'd jump up for me."

Female physicians felt sorry for nurses, whose reputations were negatively effected by engagement in sexual flirtation.

> I feel sorry for nurses and all the sexual jokes. Male M.D.s actually say that most nurses are just looking for a husband. Some female M.D.s say it too.

The use of sexual manipulation was perceived by one female physician as being a form of sexual harassment.

> With the male M.D. and nurse, there is obvious flirting and interest beyond taking care of the patient. This is normal, and it is there. This means of communication is not available to the female M.D. But there is manipulation, by both male M.D.s and female nurses. This is degrading to the nurse. It's very sad that so many nurses respond to this, especially by the older M.D.s who have a wife and kids. To let these men squeeze and pinch and manipulate and use, because they are powerful and if you don't humor them, they might wind up saying something in a committee meeting which could cause you trouble. It's very political. These men use this when they can not gratify themselves sexually or in other ways, or if they think they have gotten old. They then turn to power to feel accepted. And they have the power to force people to respond to them. Sometimes if there is no response, they turn to yelling.

Some females were ambivalent about flirting.

> It's a double-edged sword. One can take flirtation two ways: It may be nice to get these attractive compliments, but then one can get annoyed at the "sexual object" connotation.

One woman was insulted at professional references to her sexuality, especially when this superseded her abilities.

> One time an evaluation said of me, "Young, attractive, etc." "Attractive" is sexual and had nothing to do with my ability as an M.D.

Humor was also used as a stress reduction technique, especially in dealing with life and death situtations.

> I see humor with younger nurses and M.D.s more, but personally I have seen humor interjected under stress to reduce a tense situation. This doesn't seem to be sexual. I'm older and married so I'm not as aware of former. I don't notice.

Intervening variables pertaining to experience, age, competence, amount of work, institution, personality, and physical attractiveness of men and women were identified.

> It also depends on how experienced one is; whether the doctor and nurse are beyond all the flirting and just deal with each other as people. "Well she's a nice doctor, she does her work, therefore we can joke." Also has to do with how people function in their job as an M.D. or a nurse because if somebody is a lousy nurse, I'm not going to joke with them at all. Reverse is true with nurses. If I don't meet up to my responsibility, they won't joke with me either, and will give me a hard time.
>
> On the whole, there is less kidding and joking between women if there is a lot to do and if the house staff is busy. I think it's different in a setting where things aren't as tense all the time. It depends too on the personalities involved, because a female M.D. can have a good relationship and be amicable with the nurses and the support staff.

In another hospital in another city, I saw much more attention paid to men by nurses. Young women and young M.D.s were friendly and dating, therefore the nurses were responding quickly. I couldn't get things done as fast or as easily. It is not the same here.

I like to joke; it's my personality. I don't notice a real difference between men and women. It's more dependent on personality, although some female M.D.s are cautious in what they say, maybe feeling nurses are against them.

There is not necessarily more humor between a male M.D. and a nurse. Well, it depends on the age of the nurse. If she's a young, single, and marriageable nurse and he's a young marriageable M.D., then there will be an element of flirtation. I'm not sure that I don't joke and laugh with nurses as much as everybody also. I don't know if it came as early for me as it did the men. I'm not sure whether it's inherent in me.

On a professional basis, I don't foresee a difference if I'm viewed just as a physician. What I see happening sometimes are certain romantic type interests going on. Then there is a difference. But if both feel mutual respect, there is no difference.

Flirtation? Yes, between single people, and this is definitely more likely to happen in an impatient setting. Life is more amorphous in an impatient setting.

Nurses

Nurses recognized that humor, in the form of kidding and joking, was markedly less frequent in their interactions with female physicians than with male physicians. Furthermore, they viewed this as being positive.

There isn't the kidding with female M.D.s and nurses. It's a lot more serious relationship but also a lot more substance to the relationship. They also talk to nurses more about families and personal life. If I ask how their Thanksgiving was, a male will say nice. A female will say I went to so-and-so's and I cooked this, etc. They talk about kids too, so you feel you know them as a person. Whereas with a male, unless you really work at it, you don't even know how many kids he has.

Joking and kidding, particularly off-color jokes, were regarded and accepted differently between men and women.

> Nurses will tell more and listen to more jokes from a male M.D. than to or from a female M.D. These are often off-color jokes. If a female tells a dirty joke, many think it's disgusting.

Nurses felt that decreased amount of humor among themselves and female M.D.s reflected the female M.D.'s desire to be perceived as competent in her role.

> I know I joke around much less with female than male M.D.s. I don't remember hearing or telling a dirty joke to a female M.D. Whereas a male M.D. would come up to us and say, "Hey, have you heard this joke?" Maybe female M.D.s want to be seen as competent professionals, and not frivolous.
>
> I definitely see more humor with males than females. A lot of it is sexually based, but I do think a little comic relief is good. With the female M.D., maybe she's not quite relaxed enough in her role. The female M.D. to nurse relationship is more serious. There's a lot more humor among nurses.

Nurses noted humor between women, but saw it as being qualitatively different and engaged in for different reasons, than between men and women.

> The way a nurse asks a male M.D. to do something can be different. Same for the way a male M.D. might ask a nurse to do something. There can be a little teasing, etc., but I do think there is joking between female M.D.s and nurses that I think is just good humor. I don't think it's teasing or trying to make people blush.

In a seductive environment, teaching and learning took on an ulterior purpose.

> If there was a young cute intern, you made sure you had a problem. You asked for teaching.

There was appreciation among nurses for the lack of humor and seduction between women.

> With women, you can skip right over the bull.

One nurse felt that nurses perpetuated sexual humor with male physicians. The sexual game was manipulative from both sides, and sometimes even resulted in punishment.

> Yes, there is more kidding and joking with males. Absolutely! In this institution in order to get something done, he has to be flirtatious and appear to be pseudo-interested. So he acts like a big man on campus because he has to get his patients cared for. He'll use this to get it. If a male M.D. doesn't, he'll get a hard time from the female staff and then his life will be miserable on the ward. His patients will "go to hell" and so will he at 3 A.M. in the morning when the nurses decide to wake him. So a man is forced to do this flirtation to get along and get what he needs. You can watch men trying to be seductive with women and women doing the same. A lot of sexual undercurrent. The M.D. being powerful and knowing, and people sucking up to him.
>
> Men use manipulative techniques because they work, and nurses perpetuate it. Nurses who are attractive and available do special favors.

Humor and manipulation was not conducive to lasting professional colleagueships and often had more serious ramifications.

> It's a dating type humor which nurses use to attract, and the men know this and utilize this. I heard a conversation between two men (one just engaged). The other said, "Well you can now expect a lot less assistance from nurses in what you are doing."

> This is also why the male M.D. tends to familiarize himself with nurses more... so he can get things done more. Just be flirtatious; you don't only have to have a bedside manner, but have to have it with female co-workers. Because the male M.D. is a male M.D., he tends to use this to manipulate the female, knowing full well he is not interested in anything beyond what unit he is on at that time. He may purposely set up situations to get the women fighting with each other, especially if he is attractive. He may extend himself to a certain nurse and may not do it for a certain other nurse. He may have, at one time, had a relationship with one R.N., which is now over, and he's gone on to someone else. She (unknowingly) now talks to his past affair...when all the time he may be married. So now two women hating each other and nothing is getting done, and he is in Scarsdale. So male at fault a lot for some of the situations which occur between staff.

One nurse felt that male M.D.s welcomed the nurses' attentiveness towards them.

> The male M.D. will certainly try to use the sexual thing to try and get in with the nurse. A lot of this. Male M.D.s want to be friendlier. They call us by first names. Touch us more. Males seem to want to get friendlier than females do. I think it's a man being a man. They want to have women like them: to boost their own ego.

Nurses used humor and sexual manipulation to their advantage in getting what they wanted for their patients.

> In labor and delivery, you kid with them (the men), be friendly, keep them in a good mood, and get them to do what you want, rather than just be up front. This doesn't happen with women.
>
> I've seen nurses use humor with men as a manipulative tactic to get something. I've done it myself. I don't know if I count it as humor. It is sexual. In getting men to answer pages, I'll use a sexy voice so they'll answer.
>
> You hit a playful note in order to grasp their attention, and then we (nurses) get what we want.

Manipulation (sexual or otherwise) became a power strategy used by nurses in dealing with male doctors.

> There are times when creative manipulation is in the nurse's best interest. Nurses don't literally give up chairs anymore, but figuratively some still do.
>
> I approach a female M.D. totally different than I do a male M.D. In approaching a female M.D. it's medical to medical, female to female...strictly the knowledge, give the facts. With males, I kind of let them lead the stage. Males tease more. I use manipulation; let them think it's their deal. I'm always aware of the sexual difference; I'm a woman, he's a man. I think women grow up learning to manipulate. Men grow up macho, in control, etc.

Manipulation by women was viewed as a behavior learned in our society.

> Women are taught how to manipulate men. Society teaches us how to make the male happy in order to get him to do something. So females have to learn how to deal with each other on a different plane.

And while manipulation tactics did not occur as frequently between women, this lack of occurrence did not mean the elimination of problems.

> Communication is different, even difficult, when the nurse can't use manipulative tactics with the female M.D. on the usual level she does with the male M.D. On the other side of this is the female M.D. who tries to put herself on the same plane with her male counterparts. This happens often.

Some nurses admitted that some flirtacious humor was normal and healthy unless carried to extremes.

> There are more personal conversations with the female M.D.s, such as where they work-out, clothing, and children. On whole, there is more joking and flirting with the male M.D., but it's normal and healthy to be attracted to a man and vice versa; no matter where you are it is going to happen. As long as it doesn't get out of hand.
>
> Socializing is a benefit at this hospital. You do hope to meet somebody that you can date. A lot of people come with that in mind. When deciding whether to work in a teaching vs. private hospital, this is a consideration. And it is not a bad one; there's nothing wrong with this unless it interferes with patient care, or if unprofessional (i.e. a noisy party in nurses' lounge and the loved ones of a patient on a ventilator see this). This is wrong.
>
> Let's face it--a lot of young nurses might not consciously think, "I want to marry a doctor." But they are exposed to a large number if interns and residents close to their age (at least for first few years). A bevy of attractive, intelligent, articulate, powerful, flattering, and potentially rich men. This is flattering, because if a nurse has experience, she's doing the teaching. This stops as nurse gets older and as M.D. gets older.
>
> Flirtation is within the humor and kidding. More jokes between male M.D.s and nurses. I think it's to attract attention. The nurse wants to prove that she's there to be noticed. I see nurses do this particularly if they are divorced, single, or unhappily married. There is active "looking" going on.

There were limits to sexual games and attracting, and these limits were set in relation to patient care.

> I believe humor is healthy but the humor is definitely more sexually oriented with male M.D.s and nurses. With the men, there is always the underlying sexual issue right off the bat. Just innate; you're attracted. If he's married, he's out of bounds (possibly). If he's single, I may think I'd like to get to know him. With women, this is not a part. But with a man, he might get to talk to me more the first day because he is cuter. But if he's incompetent, I draw the line. Overall, my number one consideration is patient care. He can charm me, but if he's cruel to a patient, he becomes negative.

Some nurses felt that some of their contemporaries were out to marry a doctor. The way they treated a "potential" was different, often at the expense of their own professionalism.

> I think there are nurses with whom one of their goals in nursing is male exposure. They see M.D.s as a successful men who make lots of money. Many times a nurse won't confront a male M.D. with an issue because they don't want to irritate him. They want him to like them. This can compromise patient care. A nurse will sometimes let the social aspect jump into her professionalism. She wants to present her person...her feminine person to this M.D. So if he leaves a mess, she might comment but in a humorous way, so as not to insult. To others, like a female M.D. or an out-of-bounds male M.D., it's, "Go over and clean that, I'm not your mother."
>
> The intimidation women feel from men is a sexual issue. You might not like a certain male M.D., but will still allow the intimidation because he may have a friend. I've seen nurses plot and plan. And they've stuck to it...and achieved it.
>
> I think the male M.D.s that I've worked with are more likely to date a nurse than a female M.D. There is less competition. Also most nurses are so enamored by the "Doctor" syndrome. The female M.D. isn't. And many male M.D.s like being enamored.
>
> There is a lot of flirtation between nurses and male physicians. Sometimes it's used as an attempt to get the male M.D. to do something, or to just attract him to her. This goes on too much. I have very little respect for nurses on a "Doctor" husband hunt. I'm embarrassed about some nurses' lack of ability, yet they flirt a lot to wrap an M.D. around their finger.

Others saw joking and kidding as a being related to some women's low self-esteem.

> I see joking and playfulness, but I don't prefer doing this. I want to keep my work relationship on a professional basis. When I see it taking place, I ask why? I think it's because women feel inferior and in order to cover it up, they play act. They are uncomfortable so in order to get rid of this, they joke around and play and laugh and tell jokes--to get rid of the discomfort. With the female M.D.s, there was no joking and kidding; I don't see any.

A feeling of equality with a female physician caused a positive sense of esteem.

> I see myself interacting on a basis that I'm an equal, not as an equal to a physician, but as a female equal to that female. Even with our education and role differences, we can relate to each other at a median point.

Nurses felt that not all humor was sexually motivated, or was exclusively between men and women.

> I do think there is a lot more flirting between nurses and male M.D.s. But there is also joking and kidding in a light humored way with female M.D.s and nurses. In high pressure areas like ICUs, humor is needed to relieve stress.
>
> Some of the humor with males is not always flirtatious. Humor is a great stress reducer. It puts everybody on an equal basis.
>
> Some humor is healthy.
>
> If a nurse is uncomfortable with a male, she'll probably add humor to reduce the stress. Nurses and M.D.s who can use humor are more relaxed about what they are doing, and are usually better at it, and not as uptight. Then it's not as difficult to work together. A "dead seriousness" all of the time creates tension. Not that you're laughing your head off. One has to know the difference between when to be serious and when to have humor.

There were intervening variables identified by nurses. These related to whether individuals were married or single, their ages, and personalities. There was one nurse who felt that there was no difference in the amount or type of humor between women as opposed to men and women.

The teaching-learning transaction is different in the sexual area. With those who are single, there is more flirting in interactions about a patient.

Humor? I think there is an element of truth to this. It may depend on the age of a female M.D. and nurse and their marital status. Clearly the marital status of a nurse or present relationship status of a nurse does play into this.

With females, I can lay the sexuality aside. At the same time I enjoy men, and if there is not the ego problem, this makes for a good working relationship.

Kidding and joking? A lot of single people are interns and nurses. There is more socializing between this group, but it didn't affect doing their job. I didn't see much putting an arm around while asking someone to do something. If it needed to be done, they asked forthrightly. Humor no more or less between female and female than male and female.

Apology

Emergencies occur frequently in hospital settings and produce situtations which are emotionally trying and tense. In this environment orders are sometimes given in an abrupt manner. Female physicians found that, like their male colleagues, when times were tense their behaviors were firm and quick and their expectations demanding. Yet female physicians perceived one difference: they often felt guilty afterwards.

Female Physicians

I have found myself in situations where things change rapidly and I have to be giving orders. "Do this and this!" I become irritated because it's a tense time if things aren't done fast and right. Yet later, I feel almost guilty. Was I rude? Feeling later I had to go out of my way to sort of be friendly again with this person to let them know I wasn't trying to be rude...that my behavior was out of necessity. I don't think the men worry about that. They don't! If they are yelling and screaming at nurses during this situation, they don't worry about it that much afterwards. They

> think it's part of their job, and the nurses should know that their behavior was because of an emergency, so that's that.
>
> I find myself apologizing all the time. This is true, very true. "Who was that who called me in the middle of that emergency and I yelled at you? I'm so sorry." And I do think the nurses appreciate this. I feel better if I apologize.
>
> As a woman, I feel it's not right to take out your fears and angers on someone who didn't deserve it. I'm not sure about men. Can't say I remember any man apologizing. Even if another M.D. confronts a male M.D. about his anger to nurses, often they'll just get, "Well they'll just have to understand it--that's me."
>
> If I yelled, I've told nurses I was under stress and was sorry. But it is easier for a female M.D. to say, "Boy this was bad." I even go over and give a hug to thank a nurse.

Female physicians realized that women sometimes find it difficult to take orders from other women. This is exacerbated when those orders are given firmly and immediate compliance is expected. However, it was acknowledged that automatic obedience was likewise undesirable.

> An inherent basic problem is that women don't like to be told quickly by another female what to do. Not that anybody likes to be told what to do by anybody, but when a male tells a female what to do, and do it quickly, they just do it! They might not like it, but they do it. They don't have the first split second reaction of, "Oh, I don't like that," although resentment might come a little later. But with a female, initial reaction might be "Hey, who are you?" It is a problem being a female and dealing with this, but I don't think that the converse is really appropriate either. So I would rather work out this problem frankly, than have the automatic acceptance.

One female physician was cognizant of differences in, and resultant impact of voice tone and body movements between men and women.

> Apologies? I don't think that men don't worry about this because they are uncaring, but because it is not a problem. When a male yells at a woman, it is not the same as when a woman yells at a woman. That's for sure. I'm a petite women so I'm still trying to

> establish a firmness of body language because I know there are times when I'll need it. Big females don't have quite the same problem. "Flossy" (or lacy) women have a problem. A large man with a deep voice has an easier time ordering people around than does a woman. If a woman yells, first it's not as effective as a male. A yell in a high voice is not like yelling in a low voice. Second, the general way that women move is definitely different than the general way that men move. Male movements are interpreted in general as being more deliberate. Females, in general, have smaller body justiculate movements and are less likely to articulate in the broad ways that men do. So in a crisis situation, where there is talking and moving quickly, I think there is a lot of body language that is interpreted as less directive coming from a female than a male.

The reasons female physicians voiced for feeling a need to apologize, even if their anger was deemed appropriate, reflected their belief in the way women were socialized.

> Apologizing? Absolutely, I do this. I always apologize. I do not see men doing this. Why? Upbringing.
>
> We apologize because of sexual upbringing. Women are conditioned to be nice. Men can be aggressive and pushy to get what they want. They reserve being nice for certain situations.
>
> Women tend to get caught up in this whole guilt. They feel they have to apologize, instead of just doing the job. Women are raised to feel guilty if they get angry. Understanding their role is a factor too. Female M.D.s are beginning to be more comfortable in their role, therefore seeing less guilt. Also I've seen when a male is down and out rude, he will sometimes apologize.
>
> Men are allowed to express anger. Women aren't supposed to. We are socialized this way. A lot of times I bit my tongue. If this were a guy he'd raise cain. If I do get short, I give an excuse and apologize.
>
> I'm not comfortable with anger. I once leveled strongly with a male M.D. over a patient care problem, and it felt very good to express it.

Another reason given for the tendency of female physicians to apologize was reflected in the perceived predisposition of women to attend to hurt feelings.

> Women do apologize more. Again we female M.D.s can pick up on the subtle behaviors that might have caused hard feelings. This aspect might have gone totally over the head of most male M.D.s.

Female physicians felt that nurses were less forgiving of women whenever adversarial behavior was exhibited.

> I've seen some male M.D.s be very cruel. They have called the nurses names because they didn't respond to their needs quickly enough. I've never seen them apologize, but I also see eventually that the relationship between that nurse and M.D. returns to the way it was. With the female M.D.s and nurses, I don't think this happens. Someone needs to make a move to reestablish any bond or else the nurse will never again do anything for you.

Professional and other expectations contributed to "structuring" situations where apologies may be necessary.

> I have apologized on many occasions. I'm irritable when tired and I have always tried to apologize. One time, after a certain incident, I went to the nurse to ask her if I had given her a hard time and what was our problem. I am also less tolerant with nurses. I empathize with them on one hand, but yet I'm less tolerant.

Guilt was not always the outcome of an emergency in which someone took assertive control.

> I've been in codes where people were stepping all over each other, where no one was willing to take responsibility. I have no guilt in yelling and telling them what I want done, and I appreciate

> their cooperation. At the end of the code I always thank them for what they've done, no matter what the outcome. I have no guilt when something has to be done and people need to hear the orders. For the most part, people know that you are not yelling specifically at them. It is not a belittling situation.

There was a notable difference between raising one's voice to be heard during a tense time and rudeness.

> I think I'm more like a male in this way. We all know it just happens. I don't feel bad afterwards. (Maybe once or twice.) I've never been rude and would certainly apologize if I was. In emergency situations, nobody really needs to apologize if their voice was raised a little.

Nurses

When the nurses talked about this, they noted that female physicians, unlike males, did not set up situations for which they might later need to apologize.

> Usually most female M.D.s are easy-going. They never really lose it like men. And men rarely apologize.
>
> Yelling and screaming are not normal feminine behaviors, so women are most likely to apologize.
>
> Female M.D.s do not yell as much as males do. When they do, female M.D.s will give more of an explanation. These are lengthier, more in depth, emotional explanations. I think this is because they experience guilt and discomfort with anger. Men will apologize, but not like a woman.
>
> Some male residents will apologize but it's because they are going to be on call and they know they will pay for it then. With a lot of female M.D.s, I never hear them yell in the first place.

Nurses were not as concerned with raised voices in an emergency situation as they were with rudeness.

> A female M.D. will, most of the time, apologize for any change in behavior during tense times. And most of the time, that apology is not necessary. Because we (nurses) understand what the situation is. If the male M.D. was screaming the same things, we understand that also...as long as he didn't get obnoxious or she didn't get obnoxious. If they did, then an apology would be expected.
>
> In a real tense emergency situation where an M.D. is yelling, first of all they are nervous and concerned with getting things done. I don't remember this yelling unless it approaches rudeness. A "hurry up" is different from a "hurry up stupid." The latter requires an apology. It bothers me when someone freaks out, because in a code, we need clear thinking and calmness. Yelling can destroy this. It makes others nervous.
>
> Most nurses understand the intense pressure of an emergency situation.

Nurses did agree (with the female physicians) that female physicians frequently did apologize for behavior changes.

> I've had female M.D.s come to say they are sorry afterwards and apologize, even if their behavior was appropriate. I've never had a male M.D. do that.

One nurse felt that feminine guilt ensued from focusing on how others might interpret various comments.

> I think females are more cautious. They pick and choose their words more carefully than males do. And with females I think (even thinking of myself), if a woman says something "off," she will think about it. She may feel guilt, and be thinking that she didn't mean it that way, or wonder if she said something wrong. Whereas a male doesn't tend to do this.

Nurses admitted their different, often negative, reactions to female versus male M.D. behaviors in tense times--differences which included who was forgiven and how quickly.

> If males are rude, I think it is more acceptable than if a female is. With a female, if she's rude, I've heard said that, "She's got pre-menstrual syndrome" or "she's bitchy." But with a man, people will say, "Oh well--he's probably overworked."
>
> Women do apologize more than men. But even more, if a male apologizes, he is forgiven. With a female, it's remembered. There is less forgiving. Nurses will say a male had a bad day, but they will not say that for a woman.

Apologies also took a nonverbal form.

> Some women will apologize by blending back in...spending an extra few minutes with you. They do it nonverbally, but you get the definite impression that they are sorry.
>
> I don't think I've ever seen a male M.D. apologize for being short or rude. Furthermore a female M.D. might not actually verbalize an apology. We will see this nonverbally, i.e. by being friendly or saying, "Boy that was a rough situation." Some will say they are sorry if they came on strong. The only male who ever apologized was one who was caught in his own mistake while being arrogant. Actually with the female M.D.s, there is very little yelling and screaming. The don't feel it's their right.

One nurse reasoned that some men did not apologize because of a desire to maintain their hierarchical position on the health care team.

> Most men don't apologize because it's a threat to their leadership role. No matter how bizarre that leadership quality is, they are the leader! I've not seen a female M.D. get out of control. I have seen men out of control.

Nurses noted that men felt less guilty after exhibiting anger than women.

> The male nurses (five in our unit) can blow up at an M.D. and not feel guilty about it. The male M.D. is the same. He can get mad and not feel guilty. They only apologize if they really behaved like skunks. Most female M.D.s and nurses do usually come forward. "I may have been a little out of line," or (the big one), "I didn't mean it personally." I hear this phrase a lot.

If the nurses yelled, the female M.D. was the most likely recipient.

> If nurses are going to yell, they are much more comfortable yelling back to a female M.D. than a male M.D.

Although nurses felt female physicians apologized more than men, men sometimes apologized also.

> I have had situations where male M.D.s have apologized.

The Traditional Male M.D. Image

Physicians are traditionally perceived as being male, powerful,endowed with authority, leaders, and the center of action around which all other jobs revolve. Nurses used to be required to stand up when a physician entered the nurses' station. She assisted him on rounds, keeping his patients' charts ready, getting whatever equipment he needed, and cleaning up after he was gone. The "handmaiden" concept has described in part this role behavior. This section looks at this traditional male image, at what still remains

today, and at why female physicians and nurses feel some of this image still persists.

Female Physicians

Female physicians perceived that the male gender in our society is synonymous with authority.

> The way our society is structured is with the male as dominant, even though that is changing. There are a lot of ramifications to this, but just being male carries some authority. It's that simple; the gender alone, no matter what the competence, what the qualifications, or what the age, is significant. I guess I do think that this has ramifications in this teaching-learning transaction.
>
> One thing, in terms of an authority figure, is the difference in how a nurse feels responding to a male M.D. than to a female M.D., because traditionally M.D.s are males. They are more of an authority figure.

A female physician even recognized that she was uncomfortable when confronting males.

> Even as a faculty member, I find it difficult as a woman to discipline or be critical to a male intern or resident.

Female physicians observed behaviors of some male physicians toward nurses which perpetuated this traditional, and often negative image.

> Attendings (faculty) that are male can be role models for younger men. Some of these men are autocratic and condescending...in short, spoiled little boys. They want to be waited on. They curse. This is rare with a female M.D., all the time with males.

> Of all the M.D.s I've known who were notorious for giving the nurses a hard time, all were men.
>
> I think many men physicians are chauvinistic.

Female physicians observed a wide variation of nurse behaviors in reaction to the negative traditional male M.D., ranging from avoiding transactions to uncontrolled anger.

> Nurses may be used to Dr. so-and-so stamping his feet or raising his voice, and they are terrified of this. They are even scared to call them at home, so they ask me. They even call me at home to ask about another doctor's order.
>
> Any real out and out anger that I've seen has been between female nurses and male M.D.s. I saw one incident where the nurse finally threw an I.V. bottle at the male M.D. Another where there was blatant name calling. I've seen some real violence.

Even female physicians showed respect for older male physicians.

> I think this authority figure image of the male is an influential factor. I'm a young female just out of training. Even I, with an older male M.D., see myself being very respectful. I was taught to respect those older. It might be the same if this person were female, but I don't know, because there are so few older female models in this group.

Just as women are sometimes categorized by certain characteristics (such as nurturance), recognition was given to the indiscriminate stereotyping of men.

> I feel that nurses are more apt to approach me on a psychosocial issue than a male. I can't verify this; it's more conjecture. But I do think some males do get involved, although it might not be perceived that way. In that regard, I think a lot of men get bad press...They're lumped. In general, men are much more readily perceived as authority figures than women. This is beginning to

> change. Women are perceived as being more nurturing so they don't have to work as hard at projecting that.

Older male physicians were often more abrupt than younger ones.

> Male M.D.s fall into two groups. First, there are the older ones that bark a lot and sort of walk through on everyone. Then there are the younger, more regular guys that you can talk to.

The specialty of the male physician surfaced as another factor.

> I came from the time when the nurse stood up. But I do still see a different treatment for surgical versus medical M.D.s. Nurses will knock themselves out for surgeons because surgeons have expected it...even demanded it.

Nurses

Nurses, because of their position in the medical hierarchy, felt particularly sensitized to the traditional male M.D. image. There were many negative anecdotes recounted by nurses, two of which follow.

> One male M.D. got mad because an exam table was not prepared for a procedure the way he wanted. In front of the patient, he embarrassed the nurse. He was very rude. I haven't seen this with younger men.
>
> Some older M.D.s think we are their damned slaves. This one purposely threw something on the floor, and then told me to pick it up.

To one nurse, male chauvinism is inappropriate in both the professional and personal arena.

> I've worked with doctors I considered male chauvinists and I didn't admire that, even to the point of being embarrassed sometimes for them. You might still like him because you knew him, but I would never have that kind of a person as a significant person in my life.

Another nurse felt that the behavior of some M.D.s is learned from older traditional M.D.s who serve as role models.

> Well some doctors are like generals. They learn something from the old generals and they want to maintain the old generals' way because it always worked and they don't want to change.

One nurse found that her feeling of powerlessness made her envious.

> It makes me kind of envious of men that they are in the more powerful positions, and they must not worry about how they look to each other either. They conduct their business and don't worry about appearances.

In some cases, nurses were unable to accept this behavior without trying to assert themselves in some way.

> Some older guys would just as soon swear at you as look at you. I ignore that behavior but once one made me so angry, I called him an old fart. Great relationship after that, but you still didn't sit down and have a conversation with him.

One nurse felt that traditional male M.D. attitudes limited potential teaching-learning transactions.

> The male ego, especially the traditional male ego, well you just don't come "down" and ask the female nurse for guidelines and instructions. They (male M.D.s) may depend more on other male M.D.s rather than go to the nurses.

One nurse's observation showed how nurses have developed strategies for approaching men that they feel fit this traditional role. Their energy is diverted into trying to make a tactful presentation of information rather than into the information-sharing itself.

> The thing I value very much about having female M.D.s is I don't have to deal with the sexuality involved. You can just put that aside. An aspect of this, that I see, is that sometimes male M.D.s are threatened by my knowledge, or my observations, and I don't like that. I resent that. I've worked hard to gather what I know and it irritates me when I present a situation, and true, it may not be right on key, but there is usually data to support what I have discovered. And then they just discount it, for whatever reason. It's like they're threatened. I think sometimes males have problems with females giving them information. They maybe feel like they should have been the ones to discover it. I wish this were not so. The females don't have this; they'll just say "Oh, I didn't think about that" or "I didn't realize that." You have to be very diplomatic in how you say things to males, like, "I think" versus "It appears to be." You know what they say sometimes if you make an observation? "Oh we already knew that," or "Yes we are working on that." It's the old, "You've got to be tactful when you present the information, so you don't hurt their ego." I don't feel anti-male (feel I have healthy attitudes), but I resent having to present information in a certain way just because he is a male M.D. It's tiring; not only do you have to make the assessment, now you have to present it in a way that he is going to listen. Almost subtle or subliminal. They can take it (information) and feel flattered by it. You can tell they needed it. I lose respect for a man when I know he needs that. I am a pretty strong-willed individual myself and I'm very independent. If I know a male can't deal with that, that he has to maintain the male dominance role, rather than be eclectic, I just don't have much respect for him.

Older nurses are aware that assertive attitudes and behaviors are becoming more prevalent.

> In traditional nursing, you'd stand up when an M.D. entered the station, follow them while they made rounds, hand them whatever they needed, and then clean up after them. Now in my experience at one hospital, if they made a mess, they were expected to clean up.

Nurses did not feel that female physicians perpetuated these traditional attitudes about the role of nurses.

> You see a very dominant personality with some male M.D.s. "You're a nurse and I need you to do these things for me, but don't challenge me." I can't think of this ever happening with a female M.D.

Nurses acknowledged that they had different reactions toward younger male physicians and women.

> If a male M.D. wants something carried out, especially if he wants it right away, and especially if that male is 40 plus, they will say it in a way, "I mean it now!" There is no room for discussion. One female M.D. was able to do this also, but not many others. With women and younger men, nurses might say, "Well, who do you think you are talking to me in that tone of voice?"

As with female physicians, nurses felt that the male M.D.'s age was significant.

> The authoritative role is going out generally, but in the older M.D., you still find it. In younger male M.D.s, it is not as predominant.

The Male M.D./ Female M.D. Relationship

Female physicians are in a different role position from nurses in relating to male physicians. But because the female physician is a

female and, therefore, different from the traditional doctor, the female M.D. and male M.D. relationship was one which produced a lot of comment.

Female Physicians

Female physicians talked about negative past experiences in medical school, residencies, and practice.

> It was a liability being a female in medical school. I had that to contend with. It was really bad 20 years ago. Only four women graduated in my class in 1964. I have been around to bridge the changes.
>
> In training, women got the worst call schedules. I saw lots of discrimination, and male M.D. testing.
>
> Female M.D.s were angry because they were tested more by colleagues. Male M.D.s asked female M.D.s to do more; things that should have been done by nurses.
>
> There was even questioning among male physicians towards me. One sad story; a kid died, no one listening to me (i.e. male surgeons). If I were a man, it would have been different. I should have pushed more!
>
> There is pressure, almost disdain, that female M.D.s get from male M.D.s if they, for example, have to leave to pick up their kids from nursery school. You get the look of, "Why are women in medicine."
>
> Female M.D.s do get discounted a lot in medicine by males: "What's wrong with you, your period?"
>
> I found out I was a minority after my M.D. husband died. I got no more referrals, and never got elected as chief of the department again.

Female M.D.s also felt that society promulgated the "male" image of the M.D.

> I have a patient who told me right off that she couldn't stand having a female for her doctor. She was insistent that I couldn't possibly be good because I was a woman.

A female M.D. reiterated her own prejudices against male M.D.s.

> The female M.D. is more interested in the teaching-learning transaction. They are more interested in caring for the patient in every way. And since that's also the nurse's job, these women are able to interact on that level more. Women are more interested. Male M.D.s are only interested in being "a doctor." Other stuff is not their responsibility. A lot of my feelings have to do with my prejudices against men in general, and certainly male M.D.s.

Female M.D.s saw their roles as mothers as another reason that they were perceived differently by their male counterparts.

> Motherhood...Because of this maybe the female M.D. is not as devoted to her career as most men. Could also be why we are seen differently by men. Female M.D.s are still the primary child-care persons. They stay home when the kid is sick...where they want to be.

Female M.D.s felt they continued to be active physicians after their children were grown.

> A male doctor will peak between 35-50 years in terms of professional accomplishments. Females have that biological clock and will back off to have kids. At 50, I think we will see more productivity on female M.D.'s part, when the male M.D.s are having their heart attacks and loosing their hair.

Female physicians saw different, less altruistic, reasons why men go into medicine.

A certain type of male goes into medicine and that is one with a little less sensitivity to begin with. A very macho profession, although it's supposed to be a caring and serving profession. I think that certainly women go into it for this reason, but men don't. Men go into it for the prestige which it certainly has. Women are interested in becoming professionals and having a career, but they still have very strong nurturing characteristics and medicine is a perfect combination of that. Also look at the specialties female M.D.s choose: pediatrics, family medicine, etc. Now this may have a lot to do with outside pressures and stereotypes, but also has a lot to do with what that represents, as opposed to the sub-specialty of surgery.

The whole medicine dilemma now is based on the premise of doctor as God, with the moon rising and the sun coming down on our physicians. And I think, with the education of the public and physicians, the human element is coming back into it. And with women in it, this is more so. The less and less attractive medicine is as a financial thing, I think that more women are going to go into it...not because they are going to make gobs of money, but because there is a certain something you get back. This is probably the way education was for females; this is the way they got self-satisfaction. I think this is the way it'll be for medicine. It'll be like other countries where the majority of M.D.s are female, because it's not a lucrative field. Still a few strongholds, i.e. surgery as a male, macho thing, but even in this, slowly barriers are breaking. In internal medicine, etc., you have technical things to do, like medicines, but there is more hand holding and the comforting sorts of things, and females are more predominant. A distinct difference when one observes a medical clinic. The majority of females have a much better response from their patients. This is not to say that some males are not sensitive and empathetic...always exceptions to the rule.

Nurses

Nurses were aware of some of the problems existing between female and male physicians.

At a party, the male residents gave the female M.D., who was the head of the department, a year's supply of birth control pills to keep female residents from getting pregnant. (Some had and had taken maternity leave.) They did not give rubbers to the males...but birth control for females.

I see female M.D.s doing things together and the male M.D.s doing things together. Male M.D.s do talk about each other, but talk

> about female M.D.s in a different way. For example, I see the same talk we've heard on an executive or business level applied to female M.D.s: She's bitchy--he's aggressive; she doesn't know when to stop--he's persistent. I have seen more complaining about female M.D.s than males by both doctors and nurses.

Nurses saw a tendency for some female M.D.s to hide emotions or overcompensate clinically in order to prove their abilities and maintain professional esteem.

> I think some female M.D.s do not want to show emotion for fear of being criticized by their male counterparts.
>
> Some women do every test in the book. They may be threatened. They don't want to be caught in a mistake by males, so they leave no stone unturned. They are the first to start antibiotics, etc. Sometimes they are almost paranoid.

Summary

Gender similarities or differences between participants in the teaching-learning transaction produced varying behaviors for varying reasons. Foremost is the issue of humor. Both women physicians and nurses felt that humor between themselves, as opposed to between men and women, differed in quantity and cause. They believed that humor in exchanges between men and women was sexual, manipulative, or simply anxiety-reducing. Humor was then seen as a paradigm for various "wants and needs." For instance, many women, especially nurses, justified their use of manipulative humor as a learned and appropriate tactic exhibited by those in less powerful positions.

Conversely, both female physicians and nurses felt that there was less humor between women because the sexual element of interaction was

removed. Women also felt less need to manipulate other women. Furthermore, there were expectations of a serious professional relationship between women. Humor came after the relationship developed and, when present, was usually triggered by some situational incident.

Gender played a role in the quantity of services rendered. Women sometimes saw sexuality figuring prominently in the amount or quality of service performed for men and as a possible underlying motive for teaching and learning. This also had the potential to interfere with established bonding, especially as sexuality preempted expectations for professionalism. Therefore, women who observed other women soliciting or participating in a seductive environment became less tolerant and felt ignored.

Authority is another issue tied directly to gender and sexuality. Male authority figures are respected, even feared. Females in authority are not. What surfaced was that respect for male authority was based on social conditioning. Lack of automatic respect for female authorities was also a learned response. In both cases, the reaction was based primarily on gender not role.

Another point relevant to gender is that authority was viewed synonymously with power. Yet while one might reject this in female contemporaries, it was acceptable, sometimes even desirable, in men. Certainly, the medical doctor in our society is equated with authority and power, not to mention wealth. In this way, women saw some other women actively seeking male M.D. attention for purposes of marriage and the amenities of a secure, comfortable, and upper class future.

One final observation was that women stereotype men as authority figures. This was attributed to social conditioning--the same

conditioning that produced the stereotype of the "too emotional" woman. Many men found themselves having to disprove expectations about themselves, expectations arising solely because they were men.

The aspects of sexuality which influenced several other areas of interaction were again rooted in socialization and societal expectations of gender. Discussions on apology surfaced as a primary example of this. The participants validated that the socialization of women excluded expression of anger. Introspection verified their feelings of guilt, regardless of the perceived appropriateness of their anger. But two other things emerged: their desire not to set up situations which might induce bad feelings, and their realization that they might not be forgiven by other women if and when they caused bad feelings.

In summarizing this chapter's discussion on the traditional male physician, it was evident that female physicians refected on their minority status in the medical world. These reflections included the positive and negative ramifications of women M.D.'s variation from established traditional patterns of doctoring. Positive elements included altruistic reasons for being a doctor and strengths which women have brought to the image of medicine (as have been described in chapters 4, 5, and 6). Negative elements included perceived prejudices about and discrimination toward them by their male colleagues. Here they talked of their anger toward this medical establishment as well as toward the flaws in feminine socialization, a process which failed to prepare them to deal with these situations. Nurses interviewed expressed similar frustrations toward the traditional doctor. Nurses, when presenting data, felt they had to be more alert to the specific personality of the doctor than to the professional knowledge they wished

to present. In this same light, nurses recognized the pressure on female physicians who must prove themselves capable in the medical world.

CHAPTER 8

THE EMERGENCE AND ANALYSIS OF BARRIERS

This research has thus far shown strong evidence that quality teaching-learning transactions exist between women. This quality is in large part credited to the gender similarity of the participants. But, as will be seen in this chapter, being female did not necessarily ensure total cooperation and bonding. On the contrary, the fact that two interacting people were both women sometimes evoked hostile feelings. This chapter looks at some of these hostile feelings as they were perceived, experienced, interpreted, and projected by the interviewees. It deals with the issues of authority, feminine and masculine characteristics, jealousy, competition, manipulation, and expectations.

The Barriers Among Women

Female Physicians

The issue of authority became significant as the women interviewes discussed the barriers and competition among themselves. In fact this one issue influenced many aspects of the teaching-learning transaction. Women physicians reflected upon themselves as authority figures. Simultaneous attempts were made to define or redefine authority in light of their status, their role, and their sexuality.

> Nurses are very accustomed to male authority. We were raised in the same society. I understand this.
>
> The authoritarian role of the male does make a difference. There is a psychological father-grandfather image or whatever feeling. Women are reared to see men as the authoritarian figures in everything we do.
>
> In thinking back, by nature of being a male (which most of my peers are), a nurse would be more likely not to question, or just go along with it, or just not even think about it...Carry it out--that's the way it is. Whereas, not that nurses question me that much more, but if it comes from a female voice, it just doesn't seem as strong to them, even though in content, it is very much the same.
>
> I think because of the male image in society, particularly in medicine, people are used to the male figure. Men were considered the professional. I think nurses might feel a little insecure about female M.D.s' decisions as opposed to males.
>
> Nurses question the female M.D. decisions a lot more frequently than they do the male orders or decision making. Nurses are not as willing to give you information as they are to a male M.D. Actually they will go to my male M.D. colleagues to give them information about my patients. Why? I think it's a matter of authority. They don't see (or don't want to see) a woman as an authority figure. They see the male M.D. as an authority figure. Nurses don't want to believe that here's a female that either knows more than I do, or is telling me what to do. There is just some resentment. This goes beyond jealousy. It's not pure jealousy and not purely an emotional reaction. I think there is more to it. A

> lot of it has to do with how we are raised, and who we look up to as a leadership figure. When I was still in medical school, I heard a lot of female M.D.s say that they have to be a "bitch" on the ward. I told myself before I left medical school that I would never do this. We even had seminars in school. I told myself I would never act like that, yet every once in a while I find myself acting like that and that's because it is the only way I can get a response. And it may not be the response I like. They may carry out the (my) medical order but they may be angry at me.
>
> Most female M.D.s I know are very sensitive to this and try to tread softly and not walk on the nurses toes because it could be a good relationship, a very good relationship.

Sometimes the female physicians perceived outright hostility from nurses who could not accept the female physician as someone who gave orders.

> I think nursing is important and the patients could never survive without a nurse. It is just as important as what I do, but lot of times there is this breach in communication and how you view each other, and who is going to give orders, and who is going to take orders. This can interfere with actually taking care of the patient and doing what has to be done for the patient. Because some are so caught up in, "I'm not going to take orders from her." The patient is forgotten.
>
> There are orders that are questioned that are valid. Like, "I question this--are you sure you wrote this for the right patient?" I appreciate this because sometimes you do make mistakes and if you are tired and this is a new patient, it is nice when a nurse says, "I'm not quite sure what is going on." But if it's someone that you've had a bad relationship with all along and you write an order and they say, "Well I'm not doing it." This is a different issue as opposed to other questioning.

One saw female physicians using various educational and motivational techniques with nurses, such as explaining the rationale for their orders, listening, or asking the nurse's opinion. But use of these techniques was not always altruistic. Some of it was distinctly manipulative. Actually women M.D.s were frustrated that their orders

did not carry the weight of a male's. Women M.D.s did not always regard not having an intimidating presence as positive.

> If I tell a nurse that something needs to be done, I feel I have to justify why it has to be done. A guy just says this needs to be done and walks away. Women give reasons why. Explaining why is important because when I, a female, say something needs to be done, there is not as much impact as when "he" says do this.
>
> I see that men don't have to do this. All they have to do is flirt. The guys are still the ultimate goal. For me to get good cooperation and stuff from nurses, I have got to let them know that I care what they think. I explain to them what is going on. I don't have the advantage of being a male. It's a lot easier for me to get things done and get what I want by being manipulative through niceness.

Female physicians were addressed by their first names by other women more frequently than their male counterparts.

> I've seen nurses automatically call a male intern Dr. so-and-so. They automatically call me (a resident) by my first name. They did this to other female M.D.s also.

Female physicians saw nurses not questioning a male M.D. even if they viewed the situation as "out of hand."

> I have seen male M.D. doing bizarre things like sticking a kid 20 times when trying to start an I.V., and the nurses didn't question. I'm sure they would have questioned me!

Since women were not as intimidating, it became easier to be more honest. Honesty, however, was not always viewed as complimentary.

> We all have bad days. When I've been up 36 hours and am seeing my last clinic patient, I'm not this compassionate sweet nurturer. All I want to do is curl up and go to sleep and take a shower and have someone cook me a warm dinner (which ain't going to happen). If a nurse or female M.D. is having a bad day, I think it's easier to take their frustrations out on other women.
>
> The female M.D. does go out of her way to be friendlier with the nurses. Whenever you have a lot of people of the same sex working on a project, there is going to be friction arising. Women can be cattier than men, so one often sees jealousy and hostility from the nurses projected to the female M.D.s before the female M.D.s even know, or did anything to earn the hostility. Men, as authority figures, are free of this.
>
> I think some nurses are hostile because they look at you as another woman who is a threat.
>
> Women in a sense have to prove themselves on both sides. This dissipates when people get to know them.
>
> In this hospital, there are more middle-aged nurses. A certain percent really love the idea that there are female M.D.s. They are proud of us. It is a very favorable interaction. They deal with you better than they deal with the men. But there are some who hate their job and they just don't like M.D.s. Nothing to do with sex. Also some do resent you as a woman because they didn't have chance.

Female physicians felt that nurses' jealousy was evidenced by what they did not say.

> I don't see a sense of pride for me among the nursing staff. Among others, like even the janitors, I will hear, "Oh we are so proud of you. You are so good." In general, I've never had a nurse say this to me.

Female physicians reacted to potential nurse hostility by becoming obsequious.

> The most important thing that I find myself doing in terms of my interactions with nurses is really bending over backwards, and being very cautious about my respectfulness towards nurses. I am careful and choose my words very carefully. It's "please" and

> "thank-you" up the kazoo. And I don't feel real good about this. I don't like that I feel this way. Because it is not real. There is a falseness to it...A manipulation. I've verified this with other female M.D.s.
>
> Maybe nurses should be a little bit more flexible in expecting me to be a kind person. Like bending over a little bit more, like I do, to be extra respectful, extra nice. Even if they do feel phoney, like I do. The intention is good.
>
> Female M.D.s go out of their way to work on a friendly basis with nurses. Realizing too that there may be some strikes against them if they don't because there can be this female to female friction, probably more than women to men in medicine. I think female M.D.s recognize this and sort of go out of way to get along. And it doesn't always work. I know some female M.D.s that nurses don't tolerate. They get more upset with them than a man.

Female physicians knew they ultimately had power over nurses, even though they only chose to exert power as a final resort.

> If you tell someone that you respect their opinion, and I don't mean I'm lying, but I don't have to say this because, in the long run, nurses have to do what I say. Ultimately I have the power over nurses, but I choose not to use power unless I'm in situation where I just have to. I also don't take shit from nurses. I have seen some things, where all I can think is that this is ridiculous, i.e. I need something, and see everybody sitting on their ass. I can be pushed only so far, then my sweetness stops.

Female physicians perceived a nurse's jealousy of them to be related to the nurse's own frustrations about career choice or herself.

> There is an initial period of more testing on the part of the nurse to determine if she is going to have the same amount of respect for the female M.D. that she has almost automatically has for male M.D. A great deal of this testing has to do with questioning herself as to why she is a nurse instead of a physician. A doctor may see a nurse who, perhaps ten years ago, had no other option (not true for younger who had more choice) and are excellent and would have been fine M.D.s and they know it. They either accept it (and are happy with the pluses of nursing) or they resent it a little. Their behavior may show, especially to a new intern or resident where their experience as the nurse puts them, many times,

> in a position of knowing more. Yet this nurse maybe has reached the top of her pay scale and is not receiving the same respect in society as "the Doctor!"
>
> To a really good, ambitious, bright nurse, the female M.D. is more of a threat because she tends to leave the nurse a little dissatisfied perhaps that she isn't doing what she knows she could be doing under other circumstances. This other woman (the M.D.) is no smarter, no better, maybe even has less experience, and is in a position of authority over her. Not a matter of liking or disliking the M.D., rather the more internal questioning going on. The nurse has to be asking if she is going to be happy in her role now that the world is changing and other roles are available to her.

In addition to assessing the esteem level of women in the traditional "female" roles, one female physician felt that nurses were jealous of the female physician's more personal relationship with male M.D.s.

> You know when a woman is in a situation and decides to be, let's say a homemaker, you need to justify your existence. And to see women doing something different than what you are doing, and looking successful and fairly healthy and happy and being very competent at what they are doing, one kind of has to scratch at it because you didn't do that, and maybe deep down you would have wanted to. So one may need to tear that other woman down to justify choosing what she did. Most female M.D.s I know are doing what they want to be doing.
>
> When I'm around women who are not doing what they want, or are in a more traditional female position, one does feel the more manipulative behavior, or back stabbing. These women are not ours, or their own greatest support. Whenever you feel this jealousy from another woman who is not an M.D. but in a traditional role, it is almost like I've done something against them. They feel like they are not making it, so who am I out there trying to do this! Also they see the types of relationships that I have with other male M.D.s. I'm a peer, one of the guys. This is weird for nurses because the female M.D. is a woman, yet a peer with men. This is where I received the most lack of respect or pettiness from nurses.

Female M.D.s observed some vying among women for the attention of men, and were often unable to tolerate this behavior when it caused other women to be ignored.

> As women, we are taught to vie for the attention of the men. This is carried to the professional world. If I walk on the ward at the same time as a young, unattached male M.D., I can forget it. They won't even acknowledge my presence.
>
> I think younger women resent female M.D.s. They don't like taking orders. A lot of young female nurses are also interested in a flirtatious relationship with the male M.D.s. In OR, particularly as a medical student, I was ignored. I cried once. The nurses were outright vicious in very subtle ways. We were disrupting the routine some of them had had for years. It's not jealousy as much as competition. As a medical student, nurses didn't have to take orders from me, so jealousy not as much a factor. Rather it's another woman as competition, which is why younger nurses react differently than the older nurse.
>
> I could become irritated if a nurse was questioning my orders in, what I felt was a "testing" way. My response might be, "Well they are acting this way because I'm not taking them out to dinner, or sending flowers, or a potential date." There is jealousy on a sexual basis and the female M.D. is seen as competition. Actually the female M.D. has entry to the very people the nurse would like to be with.

As doctors, women felt less able to socialize with men. They felt their dating potential was reduced because men were threatened by their status and education. Female doctors seemed envious of single nurses who did not have the hectic "on-call" schedules of women doctors.

> There is competition with nurses, like in the Emergency Room when you see them helping the guys. But, it also works another way; I mean sometimes we are damn jealous of them. I mean they work eight hours per day, and they have time to go to exercise class, get their nails done, have hair done, put on make-up, and look great!
>
> The male M.D.s do not necessarily want to date a female M.D., who works just as hard, the long hours, and looks bedraggled and tired. Furthermore, many female M.D.s can't even go out with a male M.D. because schedules are so conflicting. I don't find much M.D./M.D. dating unless it happened way back in medical school or college where they grew up together. Also part of it reflects the female M.D. as being a threat to the male M.D. You know after you come home, someone who works a 40 hour week can pamper you. But you know, I don't have time to pamper myself let alone pamper someone else. Now I'm not the type to pamper a man. I wouldn't no

matter what career I had gone into. This has probably limited me in my dating. I think being a female physician scares off some men. She's an initial threat.

I suppose nurses never see the female M.D. as being very lonely. They don't have many dates because a lot of men are not interested in a female M.D. This gets into the whole area of male ego. I have dated men (professional and non-professional) who have a very difficult time dealing with my being a doctor. So I can go for months without dating anyone. Whereas at the hospital, and maybe this is where my resentment comes in, I see the men I work with going out with the nurses who ignore me, and then I think it does get to be a vicious cycle. I guess it's true that women don't date outside their professional arena because they don't want to deal with the male ego which is very difficult. It is not really that I don't date other people by choice. I can't deal with a man constantly telling me, "Oh you think you are smart because you are a doctor." I don't want this in my relationship.

Women's expectations of each other came up frequently in the interviews. Since women viewed themselves as a minority, they had little tolerance for individuals whose negative behaviors projected a negative image for all women. These expectations transcended job roles; female physicians had expectations of each other as well as of the nurses, and vice versa.

My opinion is that female M.D.s are a pretty tight group. There is good support, but we are more critical if one has a fault. This is because there are fewer of us, we're a minority.

There is definitely a tension between the female house-staff and nurses that doesn't exist between the male house-staff and nurses. I think female M.D.s have higher expectations of the nurses than the male M.D.s do. When I see a nurse callously throwing somebody around in the bed, or really being absolutely stupid or displaying a real lack of sensitivity, I think my tolerance for putting up with that (and that of other female M.D.s also) is a lot lower than that of male M.D.s. So I look at that nurse right in the eye and my look says, "You are being a woman jerk. And you can't tell me that you know what you are doing." The males don't react this way. I've talked with other female M.D.s and they agree; our expectations are higher particularly as related to direct patient care.

> I realize that I have different expectations of women. I had a very tragic occurrence leading to an encounter with a female resident over a patient that died. She had been very oppositional and hostile in this occurrence. I realized later how shocked I was by her response. And I realized that part of my shock derived from the fact that I would not have expected a woman to behave like this. I would have expected it from a male, and I would have dealt with it better had it been a man. I would have had more capacity to fight back and to handle this. But from a female, I was shocked. I don't know the basis for this expectation. It may, in medicine, come from nurses. What I learned to expect from women M.D.s is what I have seen in female nurses. And I somehow generalize from female nurses to female M.D.s. I get much more exasperated with the women who are hostile and resistant than I do with the men. It's like with men, well, what do you expect!

Female physicians felt that they were more competitive among themselves than they were with male physicians or nurses.

> Most female M.D.s probably interact better with male M.D.s than other female M.D.s. I don't see many groups of all female physicians. On an equal level, women are less threatened by men than they are by other women. I don't know if I could work with another female M.D. If interviewing I would give priority to a male. I worked with one female M.D. and we didn't get along.
>
> I've never had any major problems with nurses. Actually there is more with other female physicians. There most often is a bond between female M.D.s, but (and I've read on this) there are some women who are antagonistic to other women just by virture of being a woman. They feel that's there outlook on life. So with negative interactions, this comes to mind more with female M.D.s than with nurses. I have seen among female M.D.s those who disdain women. This surprised me when I first noticed. Not that many, but it sure stands out. Since there is usually a bond with other female M.D.s, idiosyncracies stand out. Interactions are abrupt or brief with these women. When other people are not even friendly, I'm not used to it. There is a real lack of a bond.

The competitiveness and expectations of women physicians often caused feelings of disdain for each other.

> When I see an incompetent M.D., I cringe. If that M.D. is a woman, I cringe more. I also have a problem with women who go to medical school and then drop out to have babies, although I'm more accepting of this now that I am mother. But I had so many male friends who didn't get in. In thinking about female M.D.s that I have worked with and trained with, there is not a whole lot of them I'd think about practicing with. A lot of them are high strung with enormous personal problems and conflicts over their role as an M.D., a mother, and a human being. A lot suppress aspects of their femininity. Also there's a limited pool to chose from; only 10 percent were female in my medical school.

Female M.D.s were competitive at the academic level.

> Women who go into medicine did it to prove themselves. Academically I could be equal. I'm not athletic, and I'm not pretty. But, I could stay even in grades.
>
> I think there is female physician disdain for women. I love having males around. I've developed male friends. I have more trouble with female M.D.s than anybody else. There is tension between women in medical school. There is competition.

The great demands of being in medicine prompted reflection on sacrifices made in becoming a doctor.

> A lot of female M.D.s are not married and many are divorced. They see nurses married with time for their family. I say to nurses, "You work an eight hour shift and have time for your kids. You can go home." I'm the one who is jealous.
>
> I would never do this again. My girlfriends think I lead a glamorous life, they emulate me. If they only knew. They have weekends off and families; they are giving to another person. "Don't you realize I never get to sleep or socialize." I carry this burden. I almost feel guilty having fun.

One female M.D. spoke of controlling the competition between nurses and female physicians by clarifying to herself the real nature of the competition.

> It is easier for female M.D.s to form friendships with nurses than with male M.D.s, because we are sisters. Although we can't forget the underlying competition between women like "my" house, "my" kids. But most female M.D.s are wise enough and smart enough to know you can't be in competition with nurses, because you have more training. You may be, or society thinks you are smarter, so one must be very aware of this. The competitiveness kind of aspect that usually crops up between women has to be under more control. This competition should not be important in female M.D./nurse relationship. That takes away some of the pressure between a female M.D. and a nurse too. The competition is not with her. The competition was getting into medical school. We can now share more.

This competitive milieu has a negative effect on patient care.

> On the other hand, regarding the competitiveness, jealousy etc., I think that the care of the patient really suffers because things get to be more nuts and bolts.

Nurses

Nurses recognized that the female physician could be a cause of jealousy because of her position and her role.

> The female M.D. has a real challenge dealing with how threatening she may be to some of the nurses and the kind of jealousy she may evoke.

The presence of female M.D.s prompted nurses to regard the limitations of the nursing profession and their own ambitions.

> I think of myself as a very intelligent woman. Often I have realized that if I went to medical school, I wouldn't have had to worry about my Mastercharge bill. Sometimes I'm even pissed off at myself because I didn't take the initiative. So maybe some

jealousy. But also there are the issues my own initiative. These are catalyzed by seeing an M.D. who I think is stupid, yet has a lot more responsibility and a lot bigger income. This is a gross inequity.

I've never not gotten along with a female M.D., but when I see a female M.D., I personally kind of stand back and look at them and wonder what it took for them to get there, and what they've had to go through, and I admire it. I've been a nurse for seven years and people have said to me, "Why don't you go to medical school." Maybe I'll do it but in the back of my mind, I wonder if I have what they have and maybe that's where I come from when I see a female M.D. I'm not so intimidated by them but I do approach them differently.

I've had to overcome my own feelings of jealousy. I'm a two year nursing graduate who is a dead-ended staff nurse. I'm facing the fact that I have to go back to school which I hate. And I don't want to go into nursing administration. I would have to force myself into this mold. So now I have to think about a career change if I want to move up. When I see a new female M.D., I say there she goes with the opportunities that I don't have. I know I chose not to be an M.D. so I can't say I didn't have the opportunity. I admit the route I chose was easier than becoming an M.D. And many women I know opted for the easier way out. They didn't want to go in for the hard core academia, therefore this has relegated them to the less accelerated professions. This doesn't imply that a nurse is less of a professional, but you have to accept your own profession here. If I look at medicine and nursing as two separate professions, there is little or no jealousy. But clearly to move in nursing, one has to get out of the staff positions which usually means away from the patient.

Nurses had ambivalent reactions to and expectations of female physicians who have, in the nurses' estimation, deviated from traditional roles as women.

The way I see it is I react differently to a female M.D., by virtue of the fact that with female M.D.s, I sometimes feel a little intimidated by them (personally). Whereas with a male M.D. I can develop a different kind of relationship, where it is more relaxed. I feel intimidated, I guess, because people are used to men being aggressive and men giving orders. With a female M.D., when you see this you sort of look at her (at times). I've heard a lot of nurses refer to particular female M.D.s as being aggressive. "She talked down to me." " She talked gruffly towards me." Yet when male M.D.s do this, nurses don't think twice about it. I've never had a bad experience with a female M.D., just a

> certain little feeling. I don't know if she's looking down on us (nurses). Yet there are some female M.D.s that I've been so comfortable with, because of the way they reacted to the patient, which was very nurturing...they touched patients, and looked at them.

One nurse even reacted by condemning the female physician for not being satisfied in a "female" profession.

> Sometimes I think, "Who are you to be a doctor. Why can't you be satisfied being a nurse?"

Nurses were sensitive when taking orders from another woman, especially if they viewed the tone of those orders as negative or condescending.

> In the nurse/female M.D. relationships, I think there are power struggles. I've seen other nurses give female M.D.s a hard time by questioning orders. Some of this is legitimate and necessary, but some is an agitation, more of a needling type. It can be very petty. It's a power struggle, possibly jealousy/envy. I think women are more intimidated by other females who are in a position over them. Nurses are accustomed to having men in the more powerful role.
>
> I've been in situations where a female M.D. was spewing out orders like I was supposed to be her robot. A real "bitchyness." I wanted to say to her, "Don't you realize we are all women. How could you approach me like this?"

Nurses resented when female physicians were more casual and friendly to male physicians than to nurses.

> I had an ICU experience where a female M.D. was very business-like and professional with nurses, but yet would be somewhat flirtatious and joking with her peers, the fellow male M.D.s. But she wouldn't act like this with female nurses. I sort of resented this...a negative aspect. I felt it was different. We were accustomed to male to male relating. I wasn't accustomed to this female M.D. to male M.D. I felt her behavior should have been more professional

> and dignified toward male M.D.s also, instead of only to us. This told me that she wasn't real comfortable in her role, and that she had to separate us. In ICU, there is usually a more relaxed climate between M.D.s and nurses. This one female M.D. couldn't do that with us, and this let me know that she was somewhat threatened, and had to separate us. I didn't admire that. She felt she had to set a status for herself which I felt she didn't need to do.

Nurses, like female physicians, had higher expectations of other women. These expectations were evident when nurses evaluated female M.D. competence, attitudes towards nurses, and certain behavioral mannerisms.

> I think nurses have less compassion for a female M.D. that does not function well. I think it's because we, the nurses, are functioning in these situations and functioning to the best of our capabilities and we recognize that our capabilities are limited. And here you have somebody whose capabilities are not as limited as yours, and yet they are not functioning. If the nurse has been working a long time and the more "dead-ended" she feels or is, the more this factor is considered...especially if the nurse is doing a lot of teaching and in the back of her head she knows this M.D. will be making up to $100,000 in three or four years.
>
> A lot of times I projected or anticipated a bond with a female M.D. that turned out to be disappointing. There was one female M.D. I thought was incompetent, yet I had really wanted to support and promote her role as a female M.D.
>
> I saw a lot of people (nurses) wanted to work with this one female M.D. They gave her points because she was female, and she didn't deserve these points because she was not worthy of what people wanted to give. She was into being a "holier-than-thou" physician, which eventually turned people off. I found this more disgusting with her than I would have with a male because I guess I do expect more out of women.
>
> Female nurses are harder on female M.D.s, because they represent "our" minority. If they mess up, we are harder. It's interesting, if they use feminine mannerisms, it becomes more irritating. For example, this one particular female M.D. flutters her eyelashes a lot, bats her eyes (not seductively, but a purely nervous gesture), clutches index cards to her chest, and rings her hands a lot. I notice many comments by nurses on these very feminine characteristics which they view as negative. They are purely unconscious on the part of the M.D.

> I like to see a good female M.D. I feel badly when I see women who are poor M.D.s, for my own sense, and because they are women. I want to see the best. I want to see some of our best M.D.s be women. I want to see more women in surgery. Yes, I'm harder on women if they don't meet our expectations. I probably show this more to a bad female M.D. than a bad male M.D.

Clothes, sometimes symbolizing economic and status differences, could trigger hostile feelings and exacerbate competitiveness.

> There is this female to female friction. It's true. I find myself doing it. I try to be more responsible and not continue doing it, because I know I am doing it. People can try to say that a female M.D. is not doing good to her patients, but it's really because she has on a leather skirt and a cashmere sweater! And the nurse is working like hell and being underpaid and here she comes along; "Who does she think she is?" By the same token, if the female M.D. is a slob, she's equally treated with hostility, "My God, you are a professional woman. Why do you have to look like that? You know, you are supposed to be representing us, so why are you here in worn out jeans and body odor?" It's like the female M.D.s have to walk on a tightrope.
>
> After a while some female M.D.s tend to take on the male M.D.'s attitude. You definitely see their clothes change to Gucci. You see this with male M.D.s also, but it's not the same. There's a tendency to see the female M.D. in competition with the nurse for the male M.D. Many female M.D.s start out unkempt, Levi's etc. Then, in couple of years you see them "dressed to kill" in "drop-dead clothes." Men are scarce especially for the professional women, so you'll see this competing for a man against each other.

Salary discrepancies between nurses and female M.D.s intensified hostility and feelings of professional inequity.

> One married female M.D., who had a professional husband, once said I don't mind be married and having a part time income, and the nurses knew her part time income was still going to be twice a nurse's salary, easily...and we're still struggling.

The perceived attractiveness of another woman was also a factor precipitating barriers.

> We are also dealing with whether a female M.D. is more attractive than you, or is she getting a lot of attention from male doctors that you used to get. Does she dress better? Nurses scope her when introduced and size her up immediately. If she has looks, a nice body, and taste in clothes, nurses tend to be more resentful than if she's unattractive. It wouldn't matter intellectually what she's got. If she is unattractive well, the hell with it. This is not as bad as someone who is attractive. It doesn't matter about the ethnic or racial background of that person; it's gender over ethnic and racial.

Women competed with each other for the social attention of men.

> On one end of the spectrum is the camaraderie nurses and female physicians have. But on the other is that the female M.D. does pose a sexual threat to nurses in terms of competition for the male M.D. or vice versa. Here though, profession is not the issue. It's the female to female competitiveness for the sexual prize. Nurses are thinking if she's cuter, wittier, sexier, or smarter than I.
>
> In nursing school they didn't teach you that you were going to be dealing with powerful men who were attractive, wealthy, and available. So now you are in a position where you are with five or six other women and here comes this man.
>
> If we are the same age, I think there is more hostility than if I were a mother figure to the female M.D., because a female M.D. can be taken under an older nurse's wings--A mother-daughter thing. But if we're the same age, there's more hostility and jealousy. Because maybe there are unfulfilled things in my life that she might be doing. I see it and recognize it. It doesn't necessarily have anything to do with the physician, but with other garbage you went through in high school or whatever, where women are competing for the attention of men. I think this could be same with the female M.D.s. A female M.D. could come on a unit where a particular nurse is getting a lot of attention from male M.D.s. Here this female M.D. is a single M.D. looking for a better life and this attractive nurse is getting all the attention. So she might be hostile towards the nurse as far as handling the unit is concerned. It does go both ways.

Nurses also recognized competition with each other, particularly as they sought rewards and gratification from physicians.

> One sees competition more between nurses. There's more cattiness and competitiveness between nurses than between female M.D.s and nurses. There is more support and pride toward the female M.D.s. But we hear comments from doctors like, "ICU nurses are the cream-of-the-crop and are much above floor nurses." Nurses hear this and it makes floor nurses embarrassed, and creates competition and rivalry between nurses of different specialties. We don't need this. The job is stressful enough without adding this.

Nurses recognized that female physicians did go out of their way to be nice to nurses, and they recognized that female physicians knew the cost of deviation from this expectation.

> A woman will deal fine with people who are nice and down to earth. Since she can't use her sex, a female M.D. has to know what she is doing and be business-like. She'll maintain a friendship with the nurses because she knows what they'll do if she doesn't.
>
> If I think about someone yelling, and it has happened to me, I think I would be more likely to take it from a man. With a woman, I think I would have more hostility, and a harder time forgetting. I don't know why. With women, I see ourselves as being so much more equal.
>
> A female M.D. goes out of her way to be friendly because she doesn't want the repercussions from nurses. A woman can not tolerate that another woman is going to be condescending, especially when this woman is exerting a "male" attitude toward another woman. This is such an insult because it is woman to woman. If a man does it, one can always say, "Well society taught him this." Female to female insults are more than an insult: They are a wound of indignation.

Nurses were alienated by indignant reactions of female M.D.s who were mistaken for nurses.

> I feel real negative when a patient mistakes a female physician for a nurse. Usually the patient asks them to do a traditionally nursing function. Immediately, "I'm the doctor" syndrome appears. It's not, "I'm not your nurse but I'll find her." There is a definite resentment at being mistaken for a nurse.
>
> I see female M.D.s not wanting to be mistaken for a nurse. They regard this somewhat offensively. I've seen instances where they quickly correct a patient or whomever. Like it's a real insult.

Nurses were cognizant of dissension among female physicians.

> A female M.D. will be more friendly with a nurse than with another female M.D. Female M.D.s represent competition. I've seen that women physicians do not get along.

Women have higher expectations of each other, especially in academic standards.

> I have seen women residents approach a woman attending in a more business-like way than the men who are more candid. I also see this woman attending as harder on women.

The Heterophilous Differences

Heterophily is defined as the degree to which pairs of individuals who interact are different in certain attributes, such as economic and social status, and educational level. Heterophily is the converse of homophily, or the degree to which individuals are similar in the same such attributes. However, if heterophilous individuals have a high degree of empathy for each other, Rogers (1983) believed that they were really homophilous. As has been discussed in chapter 6, female physicians and nurses do exhibit various levels of empathy towards each other because of their similar sex and the ramifications of that

(historical and otherwise) in our society. "Female" is therefore a significant homophilous element for women in medicine and nursing.

Yet heterophilous elements exist which often undermine any empathy between the two professions. Such elements became significant as these women looked at their patterns of interaction with other women. Disparities in income, dress, responsibility, educational achievements, and degree of professionalism were influential heterophilous elements.

With female physicians, there were a range of opinions, some feeling that the heterophilous elements should be emphasized, while others felt they should be de-emphasized. Many women were ambivalent. In the process of analyzing barriers, the heterophilous differences and their effects were important to consider. This section addresses these issues.

Female Physicians

Some female physicians felt that socializing with the nurses was not in their best interests in terms of projecting and maintaining an authority or leadership role.

> People who overlap social and work life may run into problems. For gentlemen, it's O.K. If female M.D.s do it, you've lost your authority. It is one thing to be friendly, but you're going to have to take the ultimate fall here, so you better be the quarterback.
>
> I saw a colleague of mine, when I was intern, who would socialize with nurses on a regular basis, and she didn't have a lot of authority after that. Yet she seemed to do it anyhow.
>
> When the nurses think of you as a buddy, it lowers the interaction. I've seen this happen to a female M.D. who was part of a CCU nurse group. It destroyed the relationship. I have funny

> feelings about being that friendly. It seems less professional. It's not that you can't be friends with nurses.

Others didn't feel that social and professional relationships had to be segregated.

> I haven't seen female M.D.s refuse to be friends with a nurse because it wrecks professionalism. In general if a nurse and you are friends on the outside, the relationship can be professional when it has to be. There could be some specific problems, but there's no generalization. If anything, it enhances the working relationship. It doesn't get in the way. I went to nurses' parties. They included me as one of them. This friendliness was all positive, and I was very pleased with it. In one friendship with a nurse, she became my protector. Maybe too much a friend and not enough of a nurse in one experience, i.e. not wanting to wake me up over a patient.
>
> I'm more apt to be a friend with a nurse than a male M.D. I've had a lot of nurses as friends. When you get in a difficult situation, you're both on the same side immediately.
>
> Most female M.D.s have very good relationships with nurses. They tend to be good friends with them, live with them, and socialize with them.
>
> I think female M.D.s spend much time with nurses socially.

Some physicians outlined the "pros and cons" of relaxed interaction versus rigid professional distancing.

> Female M.D.s are afraid of losing their authority if they get too chummy with nurse or if they're not rigid enough. At the same time, they will not have as much authority if very distant and cold...so trying to find a middle point.

Female M.D.s acknowledged that their male M.D. colleagues socialized more with nurses.

> Male M.D.s probably go out with nurses more because they are into dating.

One physician saw a correlation between professional distancing from the nurses and general dissatisfaction with working conditions at their large inner city hospital. She found that this "system" directly affected relationships.

> I am friendly with some nurses. If I'm close to them, I'll call them by their first name. If all of us were better paid, less overworked, and worked in a better setting, we'd all get along better.

At this same hospital, another female M.D. found connection between degree of professional respect (of nurses for M.D.s and M.D.s for nurses) and development of relationships.

> Here in this hospital, it's rare that insightful working relationships or friendships develop because there is such a division between the two staffs. The nursing staff in general doesn't hold the M.D. staff in much respect and vice versa.

How nurses addressed female physicians was a matter of concern. Some female physicians felt comfortable being called by their first names and, therefore, promoted this, often with a specific purpose in mind.

> I prefer being called by my first name. I don't know about others. Generally, most men are called Dr....
>
> Female M.D.s are called more by their first name. This is more relaxed. As a new female M.D., you wonder how the nurse feels toward you, so, I guess to relax the atmosphere, I say call me Jane. Men have always had female nurses and have traditionally always been Dr. so-and-so.

> I always introduce myself by my first name when I meet a nurse. It's very hard to stay on a formal basis with someone you work with everyday. You don't need to.
>
> I don't think someone calling me by my first name is apt to invite someone to step over boundaries. Nurses are highly professional, as much as M.D.s.
>
> Women allow themselves to be called by their first name more than males. If it is somebody I work with, I call them by their first name and expect them to do the same. This increases approachability, and takes away one more barrier.

One physician felt that her attempts to make nurses feel like "equals" caused her some identity confusion.

> In fact, I find it very difficult, even impossible, to introduce myself as Dr.... In fact, sometimes I wonder how I can let the nurses know that I am a doctor. If I go to the nurses' station and they don't know me, I usually say "I'm Jane Doe, a family physician or something like this. Rarely do I say "I'm Dr..." In some instances, this may make things harder on nurses because I don't identify myself well enough.

Another physician felt that nurses called female physicians by their first names for reasons unrelated to creating a relaxed atmosphere.

> I have seen some nurses do it, I think, to reduce my status and say, "You don't have any more power than I do."

Other female physicians felt that allowing themselves to be called by their first names was not necessary and could be negative in terms of soliciting professional respect.

I'm fairly formal. I sort of like to be called Doctor. If I work closely with a nurse, it's different. All in all, I'd tend to be distant.

First name? I don't think that's a good idea.

Everybody is called by their first name here, even men. However, when I go into practice in six months, I'll prefer the nurses to call me Dr..., because my perspective is to always maintain a professional role and relationship. This is defined by how you carry ourself and perceive yourself; then, in turn, others will perceive you as a professional. First names are for people on a social level.

To allow yourself to be called by your first name still has boundaries. This only varies if the female M.D. wants it to. I can only think of one female M.D. who allows herself to be called by first name.

First name salutations didn't so much happen unless I worked with a nurse over a particular length of time. Then each agreed to be called by their first name. But I didn't find myself needing to do this.

Whether a physician was addressed formally or informally sometimes depended on the specific institutional setting.

There is definitely no first name calling here. It's very formal. But there is no double standard. This is a mostly black hospital and everybody calls everybody (even the janitor) Mr. or Mrs. This is to show respect.

How the were addressed also depended on their age.

First name calling is more an age thing, not specific to men or women. The older male or female M.D.s are Dr.... With younger doctors, you almost always use first names, except in front of patients.

Female physicians felt that societal conditioning and family background influenced recognition of traditional status differences between physicians and nurses.

> I've never felt superior to nurses or above any one. There is no medical background in my family so I didn't get ingrained with this Doctor-as-God myth.
>
> I'm not above a nurse. And overwhelmingly the female M.D.s feel the same as me, except if their Dad was a doctor (role model). Then they definitely distinguished themselves as "the doctor" instead of a person in health care.

The establishment of interprofessional or social closeness between women reduced some barriers but, at the same time, allowed others to emerge.

> Nurses look at you as a little more equal, which in a way is bad because they don't perceive your status to be quite as high. On the other hand, you may get more information.
>
> The only problem I have had with nurses is after they have learned more about my personal life outside hospital. This is the one deterrent for getting too close personally. I have a lot of things that people want, like a nice house, etc. Sometimes I feel it's held against me. This is seen by other people as having, what looks on the outside, like everything.

One doctor saw that proving herself an equal of the nurses was a matter of her willingness to do the "dirty work" while actively demonstrating her desire not to usurp the recognized position of nurses in society or their professional accomplishments.

> I think it is nice that nurses see us up in the middle of the night without makeup, our hair is wet, and crawling under beds looking for I.V. lines. This breaks the superwoman image and I think this can stand between us more than anything, especially when nurses know that they work just as hard, and do the same things we do at home. Why are female M.D.s on the covers of magazines as superwomen, when nurses have been doing this for years? And I

> think, as they see us not being perfect but working hard, you do much for the female M.D. image, and the relationship.

The educational and status differences between nurses and physicians was considered more responsible than gender in causing professional distancing.

> When I observe the ingrained doctor-nurse relationship, I see that the male M.D.s really do feel "above" the nurses, but they don't feel above me. Those male M.D.s treat me differently than nurses.

Female physicians did perceive a difference in professionalism between themselves and nurses.

> The nurses work in shifts. For the M.D., this is foreign. I mean you are there until you have to be to take care of a patient. This is a barrier. The M.D. is there through it, yet we watch the nurses leave. Now I know many go home and ruminate their cases, maybe too much so.
>
> Medicine and nursing are different types of professions with varying educational attainments and varying commitments to career. The life goals are different and so are the responsibility commitments.

One female physician felt that the varying educational levels of nurses were not evident in clinical practice.

> I don't see differences in the educational levels of nurses, especially at the bedside. I suppose the better educated are not at the bedside.

The number of heterophilous differences seen depended on the actual status of the female doctor. Doctors still in training were regarded differently.

> The heterophilous elements of status, economics, or social are not seen as much at the resident level. For instance, in terms of money, they (nurses) are making as much or more than the doctors.

Clothing, too, was an issue, particularly for nurses. They felt that an expensively dressed female physician served to remind them of their own lesser salaries. But female physicians, many of whom were still residents, did not relate to this.

> Actually women residents, as a whole, are probably the worst dressers in the world. I'm not at the stage where I see a difference. I can't afford it yet, so I don't know. As a resident, I see nurses at a party dressed marvelously.
>
> I wear scrubs all the time so nurses don't know about my clothes. But as far as clothes for the female M.D., I feel this way; after she has caught up on her sleep, gotten out of debt, can afford it, and has time to buy them, she's usually too old to care anymore.

An established physician felt that clothes could pose problems.

> I think this a very big problem. One sees a woman physician making rounds in expensive street clothes and looking perfect. It gives her a superwoman image.

<u>Nurses</u>

Nurses as a whole did not see much socializing or personal friendships between nurses and female physicians.

> I still feel that female M.D.s don't want to be extremely buddy-buddy with nurses. They are more comfortable approaching us, but it is not like a social friendship.
>
> I saw socializing between only one female M.D. and the ICU nurses.
>
> There is some socializing but not a whole lot. It's limited. I saw lot more female M.D. to female M.D. or nurse to nurse socialization.

One nurse realized that female physicians had mixed feelings about socializing with nurses.

> In regard to the socialization of nurses and female M.D.s, I see female M.D.s really groping around for what to do about it. They tend to naturally socialize with the women in conversations on home life, etc., because there are more female nurses than female M.D.s. They sort of don't know where to draw the line. You can almost see her asking the, "How much should I socialize?" question. Sometimes you will find a really confident one and it doesn't worry her whether you're a nurse and she's a doctor, and she's mingling with her lessers. This is really nice because so much, "How should I act?" Much searching for this. (She does however, see that a lot of male doctors have married nurses.) Even with nurses, there is that old adage that nurses shouldn't associate with nursing assistants.

Nurses observed a definite distinction between the sociability of single and married physicians, perhaps suggesting the single physician's need for more social contact.

> The married ones presented themselves differently...a more professional relationship. The single ones were more social.

Nurses also observed ambivalence among female physicians in regard to how they should be addressed. Their feelings on the subject often

depended on their age, their institution, and the attitudes of nurses toward them.

> I see almost all women doctors called by their first name, but only some males. The women introduce themselves as Jane Doe, not Dr. Doe. Men would do this, maybe, after they'd been there a while.
>
> I see female M.D.s very inconsistent on this issue.
>
> The women don't necessarily allow it more than the men.
>
> Interns, male or female, were called by their first names. It is more an issue of rank.
>
> If a new male doctor is just starting, he was on first name basis because he knew you knew more than him. With the old guard, you didn't do this.
>
> All are on a first name basis in a large teaching hospital. It is not gender related in my experience because all interns and residents are younger.
>
> "The times they are a changin." Now it's a first name basis with almost everybody, except the chief...You called him "Doctor."

Some nurses were particularly sensitive to any semblance of a "double standard."

> If you are going to call me Anne, I'm not going to call you Dr....
>
> In one female M.D. practice they wanted to be called Dr..., but they called the nurses by their first names.

One nurse recognized that since nurses were less threatened by female M.D.s, they were more assertive and relaxed in calling them by their first names.

> The nurses will call female M.D.s by their first name but with the male M.D., it's Dr. so-and-so. I don't think the M.D.s ever come out and say what to call them (sometimes they do), so I think

> nurses are less intimidated by the female M.D. Also, because it's female to female, they feel more on a peer level, at least they attempt that.
>
> If both a female and male M.D. say it's alright to call them by their first name, I tend to call her Jane more than I'll call him John.

Other nurses felt that some female M.D.s still wanted to maintain a professional distance and were even insulted if addressed informally.

> No, at this hospital, they are still formal. Also they want to maintain professionalism in front of patients and find it hard to keep switching from Jane to Dr. Doe. So they just maintain the professional.
>
> If a patient happens to say Mr. or Mrs. by mistake, you can see the hairs go up on the chests of both males and females. It is like, "All those years, come on...I'm a doctor!"

Some nurses also wanted to keep forms of address formal.

> I wouldn't call someone by their first name. This is me personally. I don't see female M.D.s asking to be called by their first names.
>
> I don't see any more first name calling with women than with men. I've always addressed everybody as Dr. so-and-so.

How some M.D.s chose to be addressed correlated directly with how much they desired to emphasize their status.

> You do see more first name calling, but not all. Some are even appalled because they want the respect. It also depends on the atmosphere and staff in general. One floor I worked on was all formal. Some M.D.s are more comfortable and relaxed being called by their first name, so they feel more human. But some are really on that ego trip.

Nurses focused on income disparity, making it a sensitive issue. Furthermore, this difference alone often created professional barriers unrelated to the gender of the physician.

> I feel an M.D. goes to school longer and he or she is better educated, therefore she deserves to make more money. But the gap should not be as big as it is, because the hard reality is, in the hospital environment, that the nurse is with the patient eight hours per day. The nurse saves a lot of lives because of her observations and her contacting the M.D. But in our society the gap is so broad, and the doctor's salary continues to grow. While she makes more money, the nurse sits there. It is out of balance. I'm thinking I work holidays, weekends, overtime, plus two jobs. Society has done this more than either of the two professions. This imbalance is seen in much of society. Nurses and teachers are really helping, yet there are such poor salaries. A female M.D. deserves a nice car and clothes. I don't begrudge her, but in general doctors make more than they need too. People have to pay a lot for medical care. This is out of balance.
>
> The office is different. It's big business. In the hospital, they are not paying your salary. The nurse is taking care of a lot of patients, not just theirs, so they treat you in a different way because they want you to give their patients good care. In the office, it's just their patients. They have their own demands. They want to see 40 patients in eight hours...big money. There is less listening because the dollar is important. Big Money!
>
> I see that M.D.s resent the nurses because the nurses get to go home in eight hour shifts while the residents are working 36-12-12. But nurses will always throw back at M.D., "Well in four years, you'll be making 100,000/year." Both throw the economic situation back and forth at each other all the time.
>
> I think that the money factor does create hostility. Nurses may feel that that M.D. doesn't know anything more than they know. Sometimes nurses wonder how they got out of medical school and it doesn't necessarily mean someone who has just completed training. It could be someone who has been out for five years. Nurses think and wonder. They do talk about this. They get together and this is one subject they really talk about. "I don't know how a particular M.D. has gotten a degree and stays out to practice medicine." They do judge and they do share with other nurses adding, "And he's still making outrageous amounts of money." This creates a lot of hostility. These barriers are there whether the doctor is female or male. Nurses are looking at their profession as no longer the handmaiden. They are trained to stand on their own two feet and say this is what is happening and yet they are not being compensated for it. This will become more and more an issue.

Since money was a sensitive issue for nurses, clothing became visible evidence of that disparity, particularly as nurses observed female physicians moving toward higher incomes.

> Women will see the hundreds of dollars for one outfit. For a man a suit is a suit. Don't think about it. Don't think about how much he spent. But nurses see casmere sweaters and $150 skirts, and they talk about this. "Did you see so-and-so's outfit today?" It hits you in the face more. Even if she's in Levis, nurses talk about clothes. We often see a new female M.D. start out with unkempt hair and regular clothes, and progress to $300 suits, sophisticated makeup, and designer hair cuts. You really see the change. You watch them become materialistic.
>
> There was this one female resident who always came dressed like she was going out to dinner in a real fancy restaurant. She didn't look like she came to work and she wouldn't get her hands dirty. Nurses judged her negatively. They called her the "prom queen." If she was on call, everybody groaned. She was treated differently because of dress, not because she wasn't smart, although she was slow. Most nurse behavior was behind her back.

Nurses judged the clothes of female physicians, refusing to accept attire other than the traditional.

> If a doctor is in pants, napsack, and boots, she is judged to be hard-core. When nicely dressed, it's different. There is more respect for the neater one. This reflects more an appearance aspect than money. Just because they are residents and working hard, it's no reason to be a slob. Nurses don't look at this much with the men.

One nurse expressed admiration for the way women physicians dress and for their ability to project a desirable body image.

> If anything, we enjoy the way they dress. Very fashionable. One right out of Vogue. One skinny with five kids. We look at ourselves and say "gosh."

Nurses were quick to call the practice of medicine a profession, but were unsure whether nursing could be called one as well.

> Medicine is a profession, and nursing is still trying to figure out if they are one.
>
> We might not be a profession in the sense of a physician. But when a female M.D. thinks that I am her employee...oh does that concept make me angry.

Summary

As interviewees analyzed perceived barriers between women, they raised many questions: What were the barriers? Why did they exist? How were they manifested? How did they start? How did they affect interaction? How could they be reduced? How much was projection? How did they affect bonding of women? What exacerbated them? The issue of barriers became more complex as attempts to find answers always invariably raised more questions. Yet out of this maze of questions, four interrelated categories emerged. They were:

1.) Individual self-esteem.

2.) Perceptions of and reactions to roles of women and men.

3.) Professional satisfaction.

4.) Heterophilous elements.

Heterophily was perhaps easiest to articulate because many of its signs were tangible in the form of earned success, including educational levels, clothes, money, and power, or unearned success (inborn) such as

physical attractiveness. These tangibles often brought out the differences between medicine and nursing or between women. In the face of these contrasts, competition developed and barriers emerged.

The symptoms of these barriers surfaced as observable differences in how women treated each other as opposed to how they treated or were treated by men. For instance, interviewees reiterated that male and female M.D.s were not seen as having the same authority. Almost all agreed that nurses treated male M.D.s differently from female M.D.s. Female M.D.s did not necessarily want to perpetuate this difference. Furthermore, if female M.D.s tried to compensate for this difference by emphasizing their role (vis-a-vis appropriate addressing by title) and using their power, they ran the risk of compounding the barriers and resultant reactional behaviors.

Barriers were often related to individual self-esteem and professional satisfaction. Individuals who did not find fulfillment in their careers or in other aspects of their life could project their frustrations by denigrating others, particularly women. Hence, the presence of a female individual could trigger internal questioning or verification. This might be manifested by various behaviors: overt hostility, flaunting wealth and status, other forms of power manipulation.

Barriers existed not just between women in medicine and nursing; they were evident (sometimes strongly) within each profession. This is substantiated in their dialogues on expectation. There were mutual expectations of representing the minority through competence, respect for each other, equitable treatment, and display of acceptable feminine characteristics, to name a few. Should one fall short of these or

rebel, there was little tolerance. In short, bonding created a certain expectation; barriers resulted when it was not met. The essence of this reflects a manifestation of women's own discrimination between each other.

CHAPTER 9

THE EFFECT OF NEGATIVE INCIDENTS

Negative incidents between women often had serious and long-lasting ramifications in subsequent teaching-learning transactions. Sometimes these negative incidents were preceded by attempts to establish bonding. Hence, a transaction which may have started out as positive became negative.

Some overt negative incidents were attributable (by both nurses and physicians) to the unresolved conflicts of one or both participants, and members of each profession saw this happening in their own, as well as in the other, profession. While these incidents were usually highly unpleasant, both nurses and physicians felt that their occurrence was uncommon. This chapter looks at some of these incidents and their effects.

Unreal Expectations

Sometimes, as a female physician tried to break the barriers of traditional doctor/nurse relationships by helping out or relaxing communication practices, she felt taken advantage of. This took several

forms. First, female physicians felt that as their relationships with nurses became more casual, the nurses took certain liberties with the amount of work they expected the female physician to do. Likewise, the established comfortableness sometimes made the teaching-learning transaction too long. Finally, the female physicians perceived that some nurses overstepped the boundaries of the relationship by discussing their personal problems or being openly critical about other physicians.

Many nurses agreed that as women tried to break down the traditional barriers between doctors and nurses, certain expectations arose prematurely or unrealistically. This in turn altered or deteriorated established bonds. However, some nurses did feel that the passivity of many female M.D.s was a critical factor in this issue, because the female M.D. was inconsistent in expressing her needs.

Female Physicians

> In some respects, in trying to be an equal, I went overboard by not being just a little bit above. When you try too much to be an equal, some things get out of hand. Even though the nurses in the hospital are not my employees, in some respects it's that type of a relationship and this is difficult. We're not taught how to deal with employees. For five years I tried so hard to be an equal...Now I'm backing up. Not to be mean, but not go out of my way. People take liberties with you that are not necessarily there. They have unreal expectations.
>
> Yes, nurses do expect us to do more. It goes back to where women are expected to be everything. I do feel taken advantage of sometimes. But we just kind of let it simmer and grind on us, and when you are with other female M.D.s you blow off the steam. But so much of it is not blatant, so it's hard to point out to nurses and say, "Why did you make me get the bedpan and not Dr. so-and-so." So anger is not expressed to nurse. I remember feeling just really down. It's real disheartening when you have worked just as hard as any of the guy residents and sometimes you just really feel a lack of respect from nurses. I've worked just as hard, but can't get the same stuff done. Just because I'm not as intimidating or frightening.

I saw one female M.D. who went out of her way to be helpful. She started her own I.V.s. Nurses later expected her to do it, they didn't even try! So you go out of your way and then expectations become unreal. I see many examples of this with female M.D.s.

Yes, I have seen nurses take advantage of me. Yes, sometimes I feel used. I don't mind doing it, but I want to be appreciated. When they assume it's your job, that's when you feel used.

They expect more from you, a lot more. If I'm doing a procedure in a treatment room, they expect me to help get it together.

The nurses expect me to put my own I.V.s in. They will do it themselves for other physicians. It's probably me, my weakness.

I get a lot of questions and I know they would never question Dr. P. or never Dr. C. or Dr. H. (all men). I know that.

I'm in a position where I don't want to walk on anybody else's toes because I'm a woman and they are women. Yet you get to a point where you are doing all this stuff and you do feel used. I feel like telling them, but I know they will be offended and a female M.D. doesn't want to break the bond established. So you do, but you get into an area of being resentful (because sometimes while you are doing this stuff, they'll be having a coffee break). When this builds up, one may see reacting behaviors, i.e. snapping at nurse or doctor without thinking about it first. At this point, communication is lost, and so are any established bonds, etc. And it may be gone forever, and this is the bad part.

One result of relaxing the climate and increasing approachability was the extension of teaching-learning transactions past reasonable time limits.

Nurses call me about everything. Ask me anything. Nurses tell me more; everything....

Sometimes I almost hate doing rounds. Lots of conversation.

They stop you in hall to let you know about the little things. Some nurses drive you crazy, because they tell every little thing! I dread their phone call.

Feeling taken advantage of, female physicians redefined transactional styles, but not without consequences.

> I feel things suffer with the end result being that the nurses are not as willing to get along with you.
>
> If a female M.D. acts aggressive, there is that much more hurt.
>
> Exactly, I tried hard and got into trouble. There has got to be that understanding that there is a role difference, and you can be friendly and be a friend, but there is still a difference. We must work together and respect each other for our different jobs. It's not that one is better or higher. This can be hard. Can't be a buddy...Can be a friend, but not a buddy.
>
> I have seen on the other hand that a nurse didn't carry out an order the way we thought she should have, or omitted something, or didn't report something. I've seen those same female M.D.s act like a male M.D. would and become very authoritative, resorting to a confrontational style. She then gets all the comments from nurses, i.e. "She shouldn't treat me this way."

One female physician felt that as women became close, they tended to take personally any changes in behavior they saw in others to whom they felt close.

> Unrealistic expectations create hard feelings. If I'm mad about something that has nothing to do with the hospital (i.e. bad mood), I feel I have to defend myself. To say, "No it's not you." This has to do with women. If they get close, they take a lot personally. If a man has a bad day, people just leave him alone, but if I'm not my normal, happy self, people are displeased and take it personally. So if you establish a different, more friendly relationship, then one day you are in a hurry or curt, it strains things. This is hard.

A relaxed climate did invite some nurses to discuss, even complain about, other physicians (particularly men).

Nurses talk about other male M.D.s. They feel very free in telling a female M.D. about how male M.D.s treat them.

Nurses circulate a lot of rumors. They need to be careful about what they say about another M.D. They see mistakes and then address it in the corridors. This is not an appropriate channel.

Sometimes nurses took the liberty of discussing personal problems with female physicians.

They talk to me about their personal problems, i.e. their children (but don't come to me professionally), and they ask me to write out prescriptions as a personal favor.

Sometimes I got worn out with personal problems that the nurses discussed with me. I spent much time with them. The frequency of talking about problems, or how at ease they feel about asking comes a lot easier if it's two women involved than a man and a woman.

They ask me to look at their earache. They don't do this with males.

Female physicians felt it was their responsibility to establish limits in situations where expectations were perceived as unreal.

Yes, you do see unreal expectations and sometimes this is a little out of control. But if you want to stop it, you can. It is easy. Just say, "O.K. guys, let's get our work done." I think it is true with males too. If there is flirting going on and the work is not getting done, someone will usually say, "O.K., let's get going," and they do it. Nobody thinks anything of this. No hard feelings, just do the work. It's easy to control.

I don't think there is any nurse who would expect me to change a bed every day even though they have seen me do it. They know I'll still do it if things are really bad. But usually I will <u>not</u> take a bedpan. This is potentially alienating to the nurses but this is my limit. And having defined it, then no one will expect me to bring a patient a bedpan. If it's 4 a.m. and everyone's busy, I'll do it, but not if someone is available. Nurses have to change bedpans. I have to do rectals. None of us is untouched by excrement.

> I want things friendly, but if I'm pushed to the wall, I can become a totalitarian. "I want this done, and I want it this way, and I want it done now!" I try to approach in a friendly fashion rather than in an adversarial way. However, if that bombs, I have no qualms about becoming a totalitarian figure. As a rule of thumb, that doesn't help people or my relationship with them.

One female physician felt that it was just human nature to take advantage of an opportunity.

> If someone is going to do their own I.V., I'd take advantage of this--who wouldn't?

The nurses' comfortableness in increasing transactions with women presented the female physician with an opportunity to teach and promote the independence and capabilities of nurses.

> I've seen on the unit where a nurse has a choice of three people she can page to ask a question. She's obviously going to page the one with whom she has the best rapport. I handle this by going over things together, so they know what they can do, and allowing them to go ahead and test their common sense. Men have almost perpetuated the idea that, "I want to be in control of absolutely everything." "Don't bother me but don't do anything without me either." So nurses feel more comfortable paging us, but a better growing relationship also comes from this. I think nurses who work with female M.D.s do become more self-confident. Nurses ask questions, they learn more, they find out that they are trusted and that they know what to do.

Female physicians recognized that certain legalities actually put them in a position of receiving less help.

> One situation where women feel taken advantage of is pelvic exams. Here, by law, a male has to have a nurse in the room. So the women don't get the help, even if they feel they need it. The nurses, I think, feel they can do something else because, by law, she doesn't have to be in room.

Women were more comfortable requesting something from a female than a male.

> We don't maybe expect more of a female M.D., but we're probably more reluctant to ask a male M.D. to do something. Even I, a female M.D., have problems asking a man to do anything. I'm much more comfortable asking a woman to do it.

Some female physicians did not feel that nurses held unrealistic expectations of them.

> I've not been in situation where unreal expectations have happened with female M.D.s. It could be true that it does happen, but I've not had much experience with this.

Nurses

Nurses confirmed that their expectations could lead female physicians to feel hostile.

> Yes, I think this happens. Nurses so appreciate that someone is doing something for them that they take it for granted. They get the mind set of, "Well this person will do for herself, while this one won't and will get angry. So I'll help out the latter." Nurses should be showing their appreciation of the help and still pitch in. It is the nurses' fault that this happens. I think the female M.D. needs to be honest: "Yeah, I want to be helpful, but don't expect it of me. I still need your support." This should be shared before the female M.D. reaches the point of backing off the previous relationship. Also, the female M.D. is more likely to be a passive person. I don't think nurses do this with intent. They don't plan to take advantage of female M.D.s.
>
> I can see this in labor and delivery where a female M.D. can handle everything. She only needs the nurse for the delivery. I can see that female M.D.s can feel dumped on because they see the male M.D.s getting all the help. When female M.D.s are expected

to do everything, I can see how they'd be angry. Also, there is the legal aspect in labor and delivery. A nurse has to be in with male because it's required, but not for the female.

Yeah, on a really broad basis, myself and other nurses do expect more from female M.D.s. Female M.D.s don't react negatively but go in other directions, just so you won't expect as much. A lot of nurses do expect much more. I don't think nurses are aware of this. It's not conscious. Female M.D.s can't always do it all. If they are in a hurry, they need more help. If not, then they can do more, but the nurses are sometimes inconsistent with what they will offer. Nurses can't expect her to be at the same level all of time. A female M.D. has to perform at her level (role). And when nurses don't get it, they can become critical. Yet they would never expect this from males. They'll go and get what he needs. But because "she" does it most of the time, it's expected. I think nurses need to be aware of what female M.D.s go through to become a doctor.

Nurses were sensitive to and less accepting of changes in the behavior of female physicians.

I can see that if you have a good relationship with a female M.D. and she does have a bad day, sometimes nurses first reaction is "What have I done? Is she mad at me?" They look at it from the introverted aspect rather than a professional thing. It's like the relationship has gone so far but then stops. It is not really a friendship.

Unreal expectations? Yes, I see it and it's a shame. All of us have bad days. But if a woman blows her stack, it is not as acceptable as if a man goes on ranting. It's the same with lot of female nurses working together.

Professionalism and friendliness could not always co-exist.

I do think the female M.D. can feel used, although I have seen this with both sexes. Because if you become too familiar, there is a certain amount of respect that is lost, regardless of sex. If people start playing and joking, calling each other by their first names, or doing a whole lot that is not work related, well, a lot of people can't separate when it's time to work and when it's time to play. So when it's time to do something, some may say, "Well, he or she will do it" because you are on that level with him or her socially, <u>you think</u>! One may think it carries

> over and then when they won't do it, the nurse wonders what is the matter. This is why, in a lot of institutions, a certain amount of professionalism has to be maintained. So female M.D.s back off. If a female M.D. wants something and nobody is around to do it, she'll do it herself because she doesn't want the patient to suffer. So she does it, and nurse sees the female M.D. is not going to track them down to do it, so female M.D. may end up doing it all the time. The nurse may even think that the female M.D. doesn't want any help.

Nurses felt that offering additional assistance to male M.D.s stemmed from feminine conditioning.

> When a female nurse is dealing with a male M.D., she tends to do what he says. I find myself doing that. Not that he's more authoritative, but it seems to be because you have dealt with your father, your brothers, and your uncles. In certain ways they reinforce what you are supposed to do. Carries over from your house, the kitchen, the kids, the relationship you have with men, and you tend to want to do more for them. You'll do extra little things. Women are raised this way.

The complaints that female physicians had about nurse expectations and resultant workloads were sometimes related to their own passivity in asking for help.

> I think there's a danger of the female M.D. being a little bit of, "Methinks the lady doth protest too much." It's like saying, "Some of my best friends are..." There are different roles, and while as people we're equal, I don't think the female M.D. is doing herself any service if she's getting her role confused. If she's in a place where she requires assistance, and then not to say I need help! She has to make sure that she is not cheating herself of the support that she needs. I admire someone who extends themselves to help out of common human decency. With this type of help, I work harder for this M.D. I think female M.D.s have to ask for what they want. They don't have to be a "Pollyanna" or the big breast for everyone's needs. I think women get confused about this, and feel they may have to be a big ear. It's hard for female M.D.s in carving out their roles.

Nurses felt that their discussions of personal problems with female physicians were minimal.

> I see more because of approachability. But it's not a great deal.

Nurses were concerned about maintaining their own professionalism.

> I feel I can draw the line between personal and professional relationships. One can get personal, but at work a certain performance is expected. One works hard to develop a professional reputation, and you don't want to let personal affairs ruin this.
>
> In my experience, I haven't seen this happen. Perhaps because I've come from teaching hospitals where there is certain responsibility and we don't ask them to do things they are not supposed to. I don't see nurses taking advantage of female physicians. I might see a nurse who is lazy try to get out of doing something, but on a whole nurses are not like this.

Inappropriate Powers Used by Some Nurses

Female physicians felt that nurses had power but sometimes misused it in reaction to their feeling of powerlessness.

Female Physicians

> Nurses have power. Here at this hospital, if they are not going to do, they are not. It's back door power.
>
> Nurses like to put down medical students and interns.
>
> In my situation, the nurses know we are residents and we are all temporary. I cannot speak for what it's like in private practice. I don't think the nurses could work in a private hospital and treat us the way they treat us here. Here it is basically understood that the nurses run this hospital and that you (a female M.D.) have to cater to them and not get them angry, because they can get you worse than you can ever get them.

> Nurses love to give new doctors (male and female) a hard time. They make them go through certain "rites of passage."

Female physicians believed that nurses were more apt to exercise their power with other women, as opposed to men.

> The female M.D. does go out of her way to be friendly with the nurses, because there is more disdain shown by nurses in obvious ways like asking them to do something. Some will visibly show their dissatisfaction. With men they may grumble down hall, but they won't show it up front.

Negative experiences had future implications, and one could project that when residents got out of training, their attitudes towards nurses would be affected by these incidents.

> I've seen certain situations where I've thought, "You bitch, if I were in private practice and this was a private hospital, you would not dare speak to me this way." I think this happens to male and female M.D.s. Nurses do hold a lot of power over the M.D. Resentments build up.

Female physicians recognized their passivity in adversarial environments, especially their inability to confront directly the conflict source.

> When I define things, like this is the bottom line, I know I'm more likely to get resistance than a man. Not always, but if there is me and a man, and anybody is going to get resistance, it is me. It is easier for nurses to come down on other women than on men, and while this may happen with men, it is not up front and not overt. It comes out to me in ways like, "Well you can't bring the patient in the room because the bed is not ready" or "I'm not hanging bottle #33 until you write an order for bottle #33." It is never, "You asshole, you messed up, you were wrong, you owe me an apology." Nobody ever confronts you directly. But I've been

> with a sick patient and all of a sudden nurses are disappearing and no bed is ready. It is rare that they say I'm not going to help. I think the men get it like women, but they are more likely to stand up. In the above example I made up the bed for the patient. I put the patient in bed and I took care of her with no nurse to help me. Fine. A man would have said this is bullshit and would have gone and found the nurses. I called the nursing supervisor, after I did the work. A man would not have made the bed or put the patient in the bed. I did.

All physicians interviewed realized that nurses had increased control and power during night shifts.

> With night call, I feel good if know competency of and have a good relationship with the nurse. This is why M.D.s want to establish good relationships with nurses, because they can save you or create a lot of work for you, especially at night.

Nurses

Nurses felt that any power exerted was mainly against those doctors with negative reputations, especially if they were young and of lower rank.

> An M.D. with an arrogant attitude in ICU is in trouble. No worse nurse than an ICU nurse who gets in her head that an M.D. is going to give her a hard time. She will follow his orders and take care of the patient but at 3 a.m. he'll get called for a minor problem. I think M.D.s should be taught that they need the nurses on their side. Nurses who are angry are not even passive-aggresive, they are active-aggressive.
>
> You will hear doctors telling other new doctors coming into the ICU, "Don't piss off the nurses or your job will be three fold harder. If they like you and are on you side, they will save you over and over again. If you are a jerk, they will let you drown in it."

Passive-aggressive behaviors were more frequent than direct confrontation.

> I haven't ever seen a nurse directly call a female M.D. down because that M.D. was angry or yelling, but a lot of passive-aggressive stuff goes on. If nurse is being passive-aggressive, the female M.D. can be offended or bewildered by this and doesn't know how to respond. I think it takes a special woman to relate to this.

Passive-aggresive behavior was sometimes seen as appropriate when nurses behaved as advocates for the patient.

> If a nurse questions the orders of younger M.D.s, she may drag her feet carrying them out until she can check with a resident. This happens a lot when many M.D.s are covering one ICU patient.

Nurses with experience often knew more than the new physician, and the personality of the physician could determine whether nurses would give or withhold that knowledge.

> I've seen the younger M.D.s who are insecure be the most arrogant. I've seen some who just jumped off the school bus who want you to think they know it, but inside they know they don't. So they overcompensate by the attitude of, "I'm Big Doctor." Once their cover is blown, they get humble. If arrogant, we let them steam in their own juice. We will not teach them or help them (without hurting patient). We'll let them be knocked down a few knotches so they can see things clearly.
>
> ICU nurses have a lot of power. We feel we run the units. A lot of us have nicknames as Dr so-and-so. We have it from the attending level down. Because as an ICU nurse, we come a centimeter short of diagnosing. Our interns and residents rotate here for two months so they haven't seen what we see. More often the nurse has usually seen it. I say, "You might want to watch because this is what is going to happen." Nurses do the teaching.

Some behaviors of nurses actually created tensions and distance in relations with M.D.s.

> I think it is easier for a nurse to confront a female physician, but I have seen this happen also with males who have a quiet personality. Often men who are very personable change to more authoritarian behaviors. Then nurse backs off. Next time this M.D. comes into the unit, he or she is no longer meek and gentle; instead they are very forceful and directive. Maybe nurses do this to doctors.
>
> The first interaction is so important in how the nurse and female M.D. present themselves. If they are calm and professional without being authoritarian, then things generally go better. I think nurses forget, particularly in dealing with another female, and particularly in an ICU setting, that part of their job is to allay anxiety, not to create it.
>
> My unit has assertive and aggressive nurses. If M.D.s, for instance, leave a mess, they will hear about it in a conference room full of people. They'll definitely be corrected publicly. We're really known for causing problems with M.D.s who cause problems for us. It doesn't matter if they're female or male.

Observed Overt Negative Behaviors of Some Professional Counterparts

There were instances of overt negative behaviors by nurses or female physicians towards each other. These did not occur frequently (some had not experienced any), but when they did, they caused much anger and resentment. Consequently, the teaching-learning transactions between the involved individuals suffered. Interviewees discussed reasons for these incidents.

Female Physicians

Some nurses are so mean. I will go out of my way to avoid them, yet I see them act differently with men. They interact as if they were the nicest people in the world. It is so different and I ask, "What is going on?" Perhaps it's the authority figure of the male. There might be an age factor involved. (Most nurses are young.) Female M.D.s are also competition. They see me working with this available male (who I could care less about). I just want to get away from this hospital and not see anybody's face that I work with.

Some nurses are more reserved than others, but some go out of their way to avoid speaking to me or even clarifying orders. This is gender because these are some of the same nurses who bring the male M.D. juice. When I ask for some, they may say there's none on the ward or it's only for patients. They interact much more with the male M.D. Maybe they are not even aware of this behavior.

One time I wrote an order. This nurse started slamming books on the desk, pushing chairs, and obviously wanted to show me how upset she was. I wonder if she would have done that in front of a man.

I've met some nurses who had phenomenal anger. One nurse's face got red because she would get so angry. She treated me differently; always questioned my orders, was very impatient, and would walk away from me in a huff. But she didn't do this with men.

My most difficult time was in the emergency room. There were a couple of nurses who were extremely impatient with me and with my orders, and would act as if they wanted to dismiss them or check them out, and this was fairly late in my training. This was an unusual experience to me. My particular nature is trying to please; to reach out at a comfortable level. For the most part my relating to nurses has been very pleasant. I had not sensed the antagonism or resentment which I felt very strongly when I went to the emergency room. At times I've thought about working in E.R. to maintain my clinical skills, but I'm deterred by thinking of those nurses still working there. Their behavior was very clearly directed towards me. They did not do it to male M.D.s.

Some of the older women nurses are really hostile and act stunned as I walk in as a young female M.D. One nurse said to me, "Are they going to let you in the O.R.?" I felt like saying, "Yes ma'am, I'm going to mop the floors!" I introduced myself as Dr.___.

I had one experience where certain E.R. nurses were terrible to female M.D.s only. These nurses are very professional and

specialized. They have a big fund of knowledge in their area, and are not intimidated. They may feel they know just as much if not more than the M.D. It does seem, in some instances, to be taken out on women more. This is sexual, but also there is discontent. Also there was one leader who tried to undermine other people's relationships. I did my own work, so I wouldn't incur her wrath. Like her anger scared people so, that they did more work and she less. In one instance I asked for a urine analysis and she pointed where to get stuff. With a male, she got it. She was not even subtle, but she was an extreme case.

In some instances, the female physician's reaction to the aggressive behavior of the nurse was to counteract with aggressive behavior.

I can think of two old guard nurses. One displayed outright hostility, the other was passive-aggressive. The latter daddled around when I asked her to do something, then complained about the orders I had written. She would complain to my senior resident. I didn't confront this nurse but became stern and forceful in my presentation because this nurse was only going to cross me once. The hostile one actually yelled and screamed, sometimes even at males, but she was pointedly hostile to the women.

I have experienced some extreme negative nurse behavior. I once wrote an order which was a mistake (it was an unnecessary test). The nurse who picked up the order, tossed the chart and said, "What the hell is wrong with you that you think you can spend the patient's money like water!" Meantime, I didn't even know what I had done. In retrospect she was right, but I didn't need to learn my mistake this way. I thought I had done something much worse. I have not seen this particular person behave in this way toward the men, I think because women are less threatening. Another reason she behaved this way is every month in July she got a new crew. In my opinion, this is like playing Monopoly and never passing go. She has to teach this over and over. We learn but then move along. She, however, was behaving as if the same person was doing it instead of a new crew. I handled it by looking at her personality, thinking, if I was very pleasant and accommodating would she really see this as a weakness and pick on me, or would she accept it as peace? She was a very aggressive and not a really happy person, so I decided the thing to do was establish mutual respect on formal grounds and then work into a little more pleasant relationship. I picked up chart and in front of everybody, I shouted back and told her she had a point but I will not treat her this way, and I won't be treated this way. No one apologized but she said alright. Later I asked her to show me a procedure. Later things were alright.

> When I experience negative nurse behavior, I revert to, "I am the doctor. How dare you question me."

Female physicians felt that some nurses rejected the authority image of women physicians.

> I do know that some of the worst difficulties with nurses here have been with female residents. I can think of two female M.D.s who have had big scrapes with nurses. I also had a terrible experience with a nurse. She probably harbored jealousy and resentment towards me because on all the issues where this nurse and I conflicted were usually the very issues that most nurses and I resonate so highly. Clearly the problems were over authority. She had said to me that if I were a male surgeon, she could do what I say. But she said she could not take this from a woman. At this same clinic, there was a very authoritarian male director. He and this nurse got along very well. I think there is a subcategory of women who need this.

Lack of job satisfaction fostered negative behaviors.

> Negative nurse behavior is usually not overt, but there's a lot of passive stuff and it's more directed towards women than men. There is a bunch of passive stuff that goes on, period, because this hospital is a horrible hospital to work in. So you get the nasty, petty stuff that people do because they hate their job or feel dumped on.

Nurses in certain specialties had a reputation for fostering negative transactions.

> The best nurses that I've worked with are in intensive care, but they also have fragile egos as far as nurses go. So I'm very cordial.
>
> The emergency room nurses in several of my rotations were real angry and hostile. They have probably influenced how I relate to all nurses.

Several female physicians said that they had not seen any such overt negative behavior directed towards them.

Nurses

Nurses felt that negative incidents between themselves and female physicians, while infrequent, were related to some physicians' feelings of superiority. Many nurses reiterated that they had never experienced a negative interaction with a female physician.

> There is a small percent of female M.D.s who feel that they are superwomen or something, and they can't relate to the nurses because nurses are on a "lower" level than they are. This is not frequent.
>
> Some female M.D.s are snooty, exhibiting an, "I'm more intelligent" attitude. This really turns nurses off because most feel that the reason they didn't go to medical school was not because they were less intelligent than someone who did. The teaching-learning transactions between the nurses and these female M.D.s is bad. Nurses are even more aggressive to that woman. There is much less listening. This is a shame because patients suffer.
>
> Yes, I've seen some women who disdain women but still come full circle and want the same things that other women want...that of love, life, and kids. Yet their attitude is, "I'm so over-qualified that I can't deal with the average Jane." So you're right back into that competitive situation that we thought we were above. Female M.D.s don't date down. Similarly, who's to say the male M.D. wants the competition from his female M.D. wife? So the male M.D. marries a social worker or nurse or lawyer. Someone who is totally different. So female M.D. waits for the next batch of doctors to come in. God forbid if she is unattractive and stupid and sees all these attractive nurses.
>
> I have seen some female M.D.s who just see us as hospital employees. It's very difficult to deal with them, because they are not open to suggestions. There is less listening. For them it's more an ego thing, "I'm the doctor, and no snit of a nurse can tell me." Only a couple like this, not a severe degree.
>
> I knew one female M.D. who if she liked you, everything was fine. If not, you could do nothing to please her. She was definitely

> one of a kind. She could be nasty to all of us. She was extremely moody. She got an unrepeatable nickname. She would "chew" a nurse out for waking her up after another M.D. requested us to do it. Her behavior depended on the M.D. who requested her. She didn't get along well with female M.D.s either. But got along and would really be subservient to male M.D.s. She hated this one female M.D. The two would yell at each other. I guess she viewed herself at a cut above the rest.
>
> There was this one M.D. who had a very condescending attitude. Nurses were stupid to her. We could not suggest. It was none of our business to get involved in decision making.

Nurses recognized that if they were going to react to negative behavior, it would most likely be that of the woman physician.

> A lot of nurses will let a male M.D. rant and rave, rationalizing that his bark is louder than his bite. They ignore it and get out of his way. But if a woman does it, nurses either think or ask, "What's with you? Hey, where do you think you're coming from coming on like that?"

Minimizing future transactions or avoidance of transactions altogether were frequent reactions to negative behavior.

> If a female M.D. was particularly difficult, she was ignored. You didn't go out of your way. I mean you didn't ignore her patients, but if she was around, you didn't go out of your way to strike up a conversation. If a female M.D. was not like other female M.D.s, nurses treated her like the old guard. You kept your distance. It was better that way with less controversy. You didn't make trouble. If she needed to retain the doctor status, then that was fine. So we treated her like the old doctors who still had handmaiden concept towards nursing, and stayed clear.
>
> I remember one female M.D. who had a very controlling personality. She treated nurses like imbeciles and had to have things her way. We had to learn how to deal with her through manipulation, and also treated her as we would a traditional male M.D.
>
> Nurses will talk more with a female M.D. if she is receptive. If not, we treat her like any traditional nurse/M.D. relation, i.e. if they want to know something, they can read the nurses' notes.

> Nurses, when upset, usually talk among themselves. Things must be pretty drastic before they report to a higher up.
>
> Yes, one female M.D. was bizarre. The patients loved her, but she was very aggressive to us. Nurses did not offer opinions and avoided her, unless you had something drastic to ask her. I felt like women have come through so much together and now this lady is trying to prove that she is better than us.
>
> This one female M.D. was totally unapproachable, very formal, with no joking, and no room for personal talk. So we just asked her what she thought. We didn't say what we thought. Don't tell her anything but what you have to.
>
> You can see it in their tone of voice. They give a very annoyed presentation. This one is degrading, even yells, then is nice. Nurses were very afraid and would shy away from dealing with her. They called her a bitch. Nurses don't tolerate female M.D.s like males. They don't expect certain behaviors from women. Nurses do confront female M.D.s more ("What's the matter with you. Do it yourself.") but for most, they treat her just like a male M.D.

As trust developed, the transactional process between nurses and physicians improved.

> There was this one lady. She was a good doctor clinically, but very cold, emotionally cold. I didn't take this personally because she did it to others, male and female. "I am a doctor, you are nurse. As long as we don't forget, this it'll be O.K." This was her attitude. Finally she allowed herself to be called by her first name because every other doctor in the area was already on a first name basis. She almost froze when we did it. You were very aware that she picked up on the fact that you called her by her first name. After her third year here, she became a most congenial person. I think she realized that nurses were not threatening to deprive her of her M.D. degree. The nurses were not out get her. As she got to know us, she opened up. She even admitted sensitive things about her family upbringing.

Nurses reacted even to the possibility of a negative incident.

A female M.D. who was really nasty would be made an example of on my unit. No way anyone will get a chart for her. You'll see all the power plays come out.

Observed Overt Negative Behavior of Some Professional Contemporaries

Besides having negative observations of and experiences with women who were not in their respective professions, interviewees also saw problems with some women within their own professions. They viewed this behavior as idiosyncratic.

Female Physicians

I've seen some of my female colleagues act like the arrogant male M.D. There is no warmth in their interaction. "I am an M.D., you are a nurse." They are definitely not like a stereotype of a woman to be nice. This doesn't manifest itself necessarily as a disdain for women, just a superiority because they are an M.D. They would treat a male nurse the same as a female. It's disdain for those below them. They have intentionally gone into male dominated professions because they want that power. Unfortunately all those in lower paying jobs are women, so when you get into any position of power, those that are lower than you in the pecking order are going to be predominantly women.

I saw only one incident of negative female M.D. behavior in an American trained doctor. You see this more in foreign women, who came from definite stratified class societies. They view nurses as lower forms of life.

This negative behavior doesn't come from the feminists. It comes from a sense of self. These women work so hard, and now they try to be so tough. They are often not friendly to anyone, male or female, nurse or doctor.

I had a female resident say, "No nurse is going to tell me what to do." This same female M.D. dresses very well and is dripping in diamonds. She got in many scrapes with nursing.

Yes, I've seen a few real negative female physicians, usually older. They plowed through by fighting from the beginning. I

> don't know whether it was determination that made them fight, or if it was the fighting that turned them into grumpy characters. Only a few turned against other women and made things hard...maybe because they thought these other women had it too easy.
>
> They've gone into medicine for the wrong reasons. And they are bringing in their hang-ups. It would be same if they went into law or business. It's an unresolved something.
>
> I think there is less female M.D. disdain for women now. The older female M.D.s were forced, or felt like they were forced into that mold in order to get any place. They had to act like men if they wanted to be in a male profession. I don't think there is as much of that now because you don't have to do that anymore.

Certain behavioral characteristics of female physicians were considered racially motivated.

> I've seen some women display a "better-than-thou" attitude. But I see more of this in white women than black. However, black women have a problem with femininity. They have been told a lot that they are not feminine, so black women work very hard at being feminine, so much so to their detriment.

Nurses

Nurses felt that negative nurse behaviors toward female physicians was minimal. In fact most of the interviewees stated that they had never seen or heard of nurses reacting negatively to female physicians.

> The older nurses, still following the traditional mode, have more trouble with the new female M.D than the younger nurses, who are more of a team person. Their behavior is catty, but behind the back. They make condescending remarks. I've only seen a couple like this.
>
> One nurse I knew was disrespectful to women but not to the male M.D.s. Her behavior was passive-aggressive. She'd do something ordered by a female M.D. when she was good and ready. In no other nurses did I see this behavior.

> Yes, I have seen nurses behave negatively towards female physicians. One sees this more in an acute environment, where the nurses have been in the unit for prolonged periods of time and feel that they know a lot more. They are looking not just at female M.D.s, but it does seem to be more directed towards female M.D.s. Residents and interns are coming in and don't really know what they are doing. The nurses will say, do this, this, and this (often aggressive). You can see right away the response reaction of the female M.D.s They back off and take offense, and a lot of times talk about it after the situation is past. And say, "You presented yourself this, this, and this way and I didn't appreciate it; and you have to remember I'm the physician and I'm leading. I appreciate your help but do it in appropriate manner." In this way they teach the nurse that they won't tolerate it. I do see this happening in critical care areas.
>
> I experienced one female M.D. (a plastic surgeon) who was different: independent, intelligent, and not your stereotypical female M.D. The nurses were really antagonistic. They wouldn't do for her what they would do for other female M.D.s I thought she was extraordinary...so independent...such an individual. Even male M.D.s were mean to her. I saw real discrimination towards her from male M.D.s and nurses. She was fashion conscious and always looked good. She was also a bit arrogant. Nurses idealize arrogant men but condemn an arrogant female. They criticized everything down to her toenails. She couldn't do anything right. She had to get everything for herself. Yet she didn't have disdain for women which I have seen in some female M.D.s. She didn't have a "look-what-I've-become" attitude.

One nurse felt that some nurses' jealousy and anger toward female physicians projected their traditional expectations of women's professional roles.

> Their behavior is angry. These nurses are not at all scared of other women and blatantly show it. "Well, don't you feel you should do this?" They say it rudely. Maybe it's not just jealousy towards female M.D.s. Some may feel medicine is just for men, not a woman's role. A woman is trying to be too liberated. These are real traditional attitudes.

Summary

One result of bonding between women was the expectation of more connection between the professions. But the degree of this expectation was not explicitly defined. This sometimes led to what participants described as unreal expectations.

It became a cycle of what to expect versus what is perceived as realistic of or appropriate to roles. When expectations and reality did not correlate, some participants opted to break the cycle. For instance, the female M.D., for whatever reasons, might go out of her way to be friendly or help out more, and those who did verified that this aided the teaching-learning transactions. Yet sometimes the female M.D. felt she was being asked to do too much, to work out of her role, or to extend the teaching-learning transaction beyond reasonable limits--in short, she felt taken advantage of.

Interviewees saw two reasons for this occurence. First, they saw that nurses who acknowleded the female M.D.'s efforts tried to further the blending of roles by decreasing boundaries. Second, they felt that both female M.D.s and nurses failed to communicate assertively about what they saw as an over-stepping of boundaries. Such situations often created anger and helped to reestablish traditional doctor/nurse boundaries.

Overt negative behaviors, observed either in their own or in the other profession, were considered rare and connected to unresolved conflicts. Such behaviors included anger, jealousy, rebellion against authority, disdain for women, and attempts to manipulate. Counteractions included aggression, exertion of authority, avoidance,

withholding of knowledge, and manipulation. All interviewees saw the teaching-learning transaction deteriorate dramatically when these behaviors were present. Furthermore, both nurses and M.D.s believed that these incidents would negatively affect future transactions, despite attempts to improve relations between the professions.

CHAPTER 10

PERCEPTION & INTROSPECTION

The Female M.D.s Discuss Nursing

As stated in the Background and Significance of this research, nurses have felt that in the past physicians have had little understanding of the nursing role. As a result, members of the two professions sometimes became adversaries over what they believed to be appropriate patient care priorities in nursing. During the course of this research, female physicians were asked for their thoughts on the profession of nursing and their understanding of the role.

They recognized that the amount of time nurses spent with patients was an important factor.

> Nurses are there 90 percent of the time. They know more about my patients than I do.

> I think more and more that M.D.s have respect for nurses because they are recognizing the amount of work they do and the intensity of it. I don't understand how they can be with a certain patient all day. I can't be in the room five minutes with this patient!

> I see this teaching-learning transaction as the thing that could raise nurses up to the level of respect that they do deserve and that they can accomplish. Because of the input that they have into what is going on with the patient. My God, I might be there for a half hour of the day, but there is a nurse there who knows what's happening with the patient, how they are responding to their

> medications, how they are eating, what I should be ordering, and what is happening to the family. These things can get real complicated and the input of the nurse can be so valuable.

Female physicians recognized the significance of a nurse's experience.

> Many nurses have been around a lot. I've only seen one case of measles, so I'll listen.

Female physicians responded positively to most queries from nurses about the orders given them by physicians.

> Some of the questioning one gets from nurses about your orders is well worth while. I am questioned about my orders more in terms of why. In a sense this is good because I am a better teacher in that sense to a nurse; to actually get information across. I use that as an opportunity to do some explaining and teaching.
>
> Women are now more assertive. They don't rest as easy with what somebody says. A lot of nurses will go to somebody with a problem and if they don't like the answer, they will pursue it further. They will say, "I don't agree with you." For example, "This person is in pain; you're not giving enough medication; you've got to do something." Nurses question things a lot more than they used to. This is very good.

Female physicians were not inclined to doubt the validity of questions raised by nurses.

> I don't question what a nurse brings up. Now I suppose a male might question this more by saying, "Are you sure that this is really important?" or, "Are you just reading into it?"

Female M.D.s did see nurses as teachers, especially those who were specialized.

> I work with some nurse clinical specialists, who are so good that I need their help many times. They know, in their specialty areas, many more details of care than I do. Absolutely a reciprocal teaching-learning transaction.
>
> I work with a pediatric nurse specialist. We are sort of soul-sisters in our exasperation at both male and female residents. They'll ignore the fact that they are writing a prescription for a medicine that the patient can't afford to buy. I think nurses see more clearly the cognizance of this big picture. Nurses have this so exquisitely. This is not necessarily held by female residents.

Female physicians recognized how much they could learn from nurses.

> Nurses are much more practically oriented than we are. We have to trust them for that. They are more innovative. Our orientation is geared toward therapeutics and what's going on inside the body and what you can use to help it towards health. After I see a nurse's discharge plan, I'm always amazed at the things they think of. They don't come into my head. In this way their training is entirely different.
>
> I've learned a lot from nurses. I'm amazed at how they speak with patients. They're training is much better than ours. We're not given this. Bedside manner comes the hard way. There are no courses given or formal training in how to interact with people. There is too much memorizing of facts. I've learned an awful lot about how to be around patients from nurses. I marvel at them over the phone and how they speak with people.

One female physician saw a distinct professional difference between the physician-nurse transactional process in the clinical practice of medicine and the process in discharge planning and psychosocial care.

> It is hard to understand what the nursing profession is really all about. What are they there for? What is the identity of the nurse? And if there is none, this is a barrier too. How do you deal with this person who takes off the orders? It's not an interaction where you consult them. Now discharge planning is different. The nurse is closer to the patient so she's in a better position for the M.D. to consult her on this. Also with psychosocial problems, I have no trouble hearing this out.

Pity for Nurses

Female physicians often felt empathy and concern for women in the nursing profession, perhaps as a result of female bonding. Much of the pity they felt for nurses reflected their acknowledgement of women's rights and opportunities in different times.

> It must be frustrating to be a nurse in this day and age, because a lot of women went into nursing in the 60's. Probably if they had been finishing high school in the 70's, they would have thought about medicine. I see a lot of nurses like this. I know how they must feel. I try to understand that. Now we are over that. Women now know that they can be a nurse or a doctor, but there are those of us who got caught. I feel there are nurses who don't want to be nurses. They feel they could do more and know more and they are smarter, and this is hard for them.
>
> A nurse can see that she is fully capable of doing what we're doing. That's why I think so many go on for their M.D., and we can see she's fully capable so we have no reason to feel any better than she is.

Female M.D.s saw decreased potential for career satisfaction and respect in nursing.

> Overall I think that nursing is a terrible career for anyone to go into. Maybe alright when you're young, but the pay and time expectations are so terrible. You have to be stupid to do this. You see so many nurses go in to public health or a doctor's office. They hate this. It's boring, but it is a 9-to-5 job. In the hospital it is every other weekend and having to do night shifts. As a career, the expectations placed on you are crazy.
>
> I see nurses disappointed in nursing because of the lack of respect. Hopefully more female M.D.s will make nursing better.

Female physicians observed that while some nurses worked to make nursing recognized as a profession with its own contributions, others resisted these efforts or just failed to see their own power.

> I don't think good nurses appreciate how they can be appreciated.
>
> I know frictions between nurses exist. I see those who are trying to make nursing a profession, but finding resistance.
>
> I think nurses have more power than they realize and a lot of stifling has to do with themselves or those within their ranks (i.e. their head nurse).

Women physicians saw more career motivation in younger nurses. Furthermore, they blamed the system of nursing care delivery for some apathy and loss of professionalism in middle-aged nurses.

> In this inner city hospital, so many hate their job. They don't do nursing. They've gotten so accustomed to this that they don't care to do nursing anymore. A nice thing about younger female nurses is they're still enthusiastic and they want to nurse. Part of it is the system. Someone is assigned to temperatures, some are to this, another to that. It is like an assembly line. They don't realize that they used to be professionals. Now they act unprofessionally with patients, etc.

Female physicians drew correlations between a specific institutional system and the professionalism of its nurses.

> I feel that by-and-large the characteristics of the nursing staff at this particular hospital lack professionalism. Very, very unprofessional professional staff. There is a lot of real sloppiness in their interactions with patients, with other nurses, with other auxiliary professionals, as well as with M.D.s. A lot of this comes from the social setting the staff comes from. There is not a strong feeling of nursing as a career, a profession, or as a positive, valued thing to be doing. Therefore, it's hard to talk about differences according to sex because the most predominant factor in the interaction between the groups is based on the fact

that we are M.D. professionals and the nurses feel that they are not.

Female physicians observed overall job dissatisfaction within the nursing profession. They blamed frustration of nurses on poor working conditions, heavy workloads, low pay, lack of respect and appreciation, and minimal promotional opportunities.

There are some nurses who don't like the job that they have. It is a damn tough job...physically hard and mentally hard. It's a hard job being a nurse.

There are a lot of incidents where nursing is a go-nowhere job. Maybe you can move up to Charge Nurse or something, but basically it is a serving job, where you are following orders. I mean, there is a lot of responsibility. I'm not saying there isn't. Nurses are vitally important to what is going on, but still in society, nurses are just there carrying out orders. I don't think people give them enough credit for how much they really think and could contribute to patient care.

Only so far you can go in nursing. You can be promoted to head nurse and then what, an office? I didn't want that. If you want to stay in nursing, there is only so much mobility in terms of status, money, and respect. It's very frustrating for the people that want to get ahead. Many leave to make more money. I see them go into real estate. Nursing is an important profession. We should keep good people in it, but it has to change. I see many nurses who want to go into medicine.

Nursing has a lot of rewards from it, but too many expectations, too little money, and shift work. Look at teachers; they work nine months a year, and have holidays and the summer off. The most interesting nursing is hospital nursing, but if you stay in that you take all the bad cards. Things are not a problem at 22. It's later on when you have a family.

I worked with one nurse once who was a great diagnostician. She was brilliant; she kept things going. She saved my neck more than once. I couldn't figure out why she was working in this hospital on nights for a measely $12,000 bucks a year.

Female physicians blamed the system for the loss of certain nursing qualities important to patient care.

> The staff is so stressed that a lot of the nurturance that should be directed toward patient care is completely gone.

Female physicians also saw the effects of different unit staffing patterns and the priority given to certain units, namely specialty areas like ICU. They felt that the quality of the teaching-learning transaction was dependent on the conditions under which participants worked.

> ICU does have a very professional staff, but it is also better supplied than the rest of the hospital. So more of the stresses of this work environment are related to the actual job, rather than to the frustrations of trying to find supplies and all that garbage, or having to work with a lot of people who don't know their job, or being short of staff. In the ICU there is even a better support staff and better secretaries, etc. in this environment. Consequently, there is better respect among M.D.s and nurses in general. There is more of a team spirit. I have seen bonding between female M.D.s and nurses in this environment. We enjoy watching each other work.

Their own gratification in being physicians led some female M.D.s to pity nurses.

> Being a M.D. is a nice career. One is in a power situation. In other careers one has to work your way up the ladder.

One female physician considered the effect of differences in job satisfaction between nurses and physicians on the teaching-learning transaction.

> Nurses are proud of female M.D.s, but many also wish they were in my shoes. I see a high degree of burnout and job dissatisfaction in nursing. The money stinks, so nurses see female M.D.s in this light. Nurses see they could be M.D.s. I think this is a motivating reason why a lot of nurses are going into medicine, like I did. In nursing, advancements are not there, independence is not there, and the money is not there.
>
> The nursing profession is kind of, by definition, subservient. And how do you get out from under that. People are making great strides but it's difficult. I'm always pretty sensitive that a woman, who is in nursing, might not have known enough to maybe go and be a physician. Sometimes I feel a resentment. This is a barrier towards M.D.s, particularly the female M.D., because you identify more with nurses (your own sex). Nurses, particularly older, have said to me, "You had the chance." There is so much drop out in nursing so you are dealing with younger women most of the time. Interestingly, as I went through residency, I was similar in age to nurses. Now I'm older than most nurses, and I'm only in my mid-thirties. I'm very conscious of older women where the doors of opportunity weren't open to them; who can see that they are very competent to do a M.D.'s job, but now it's too late. So I see nurses being unhappy in nursing.
>
> Self-esteem is a common problem for women. I'm extremely happy in medicine and that goes as far to feel sorry for a female in nursing. My bias. I suppose this creates a little bit of a barrier.
>
> The nurses that I see are negative to everybody regardless of sex. Maybe more so to women. I'm not sure that if they were really happy with what they were doing and paid adequately and worked less odd shifts whether they would be happier in working with everybody. Being a nurse here can be horrible because you get dumped on and have to ventilate.
>
> I feel sorry for nurses. I see many who are frustrated, not wanting to be there. If they had made one change in their education, they could have done anything. When I went to college I was competing with men, and men gave me challenges I may have never thought about. If I went to a woman's school, my aspirations might have been different.

One physician noticed that nurses tend to over rely on physicians, a fact which points to the underestimation of their own decision-making abilities.

> Many questions nurses bring up to M.D.s are really nursing questions. I think nurses overestimate the knowledge M.D.s have about nursing.

Female physicians saw home health as providing more opportunities for autonomy in nursing.

> Home care is an area where nurses can use their high level of expertise. Where they are the doctor and go to the home, assess, do physicals...essentially the country doctor. I'm sort of surprised that nurses haven't jumped on this bandwagon; that they haven't formed businesses and corporations for this service. But I think this leads back to the aggressive thing. It's bred out of women.

Some female physicians who did not identify nursing as a profession encouraged selected nurses to change careers.

> I have seen bright, assertive nurses who I have told, "Nursing is not for you, go to medical school."
>
> I have more trouble with secretaries than nurses. A secretary's work is even more subservient then nursing. Again poor money. A bad job.

One physician compared the nurse's role in the hospital to the traditional homemaker's role in the home.

> I appreciate a nicely made bed. I know then that the nurse has put effort into it, as much for the patient as myself. I'd rather examine a clean patient. I don't think male M.D.s get into this. It's subtle, they don't appreciate. It falls in the realm of housekeeping. A well organized, well run ward is the same as a well organized home, and we spend a lot of time in a hospital, so it becomes our home. I realize the nurses are the homemakers for this place to some degree. If a ward is smelly when you walk on it, one says there must be something wrong with nursing, i.e. the head nurse is not good. She can't get the troops together to get the housekeeping done. This carries through to actual nursing

activities. I think well maybe my patients are not getting the care they should. Maybe an I.V. will be allowed to infiltrate.

Female physicians saw as positive the new sense of pride and autonomy emerging in nursing, except as it caused discrimination against the physician's input into teaching and learning.

One of the things I want to do as an attending is to teach the residents how to work with the nurses in a parallel way. I want to foster the sharing of responsibility. Nurses can teach residents about a lot of things, because nursing and medicine have different skills to draw from each other. But some nurses are actually resistant to this. I think it goes back to when nurses were, in a sense, powerless in the face of male authoritarianism. Even the Director of Nursing of Pediatrics sees distinct nursing and doctoring lines of authority and there are nurses here who share this philosophy. They are very afraid of drawing on a doctor's expertise in any way that would look like the "M.D. was the boss." In the very traditional arena, doctors in fact taught and controlled nurses and nursing is very sensitive to this feeling. Now that nursing is viewed as autonomous, many feel that nurses should teach nurses. For example, there was a mock code in this clinic, yet nurses never told M.D.s it was happening. Now you can't run a code without M.D.s but the nurses didn't want the M.D.s there.

Not all female physicians, who compared their career with nursing, felt pity.

Pity nursing? No, not so much. I mean they don't have to be on call which is horrible. I chose not to be a nurse because there was this jerk in the lab telling everyone what to do. I said I won't let him tell me. Nurses have to listen to jerks. But there is a real role for nurses. I don't pity nurses. It's a good job. I hated being a resident and intern, and being on call. I hate being on call.

Nursing is an ideal way to be active in the medical field and still have a family. This is more difficult for an M.D.

I strongly believe in the joy of doing any job well. I respect anybody that does their job well. Any job can be a challenge. Now I do think if you are operating under a situation where no matter

> what you do you just get squished all the time, this gets to be pretty tough in wanting to meet the challenge. But I think that nursing can be as rewarding as being a physician, maybe even more so because there is more opportunity to be nurturing, to interact in more than just a short time span, and this is satisfying. I think the problems occur when nurses are really not allowed to do this and they are more worried with the overwork. This may be part of what's happening in teaching hospitals. If there is not time to develop a relationship with a patient, this is a problem.

Some female physicians interviewed had been nurses previously. Their comments reflected an increased understanding of the nursing profession and, sometimes, increased expectations. All female M.D.s spoke from to perspective of "when I was a nurse," not considering themselves nurses any longer.

> I think my perspective may be different because I was a nurse before I was a doctor. I know how important a nurse can be because I was one and I know that the information they can get is very important, so I am looking for that in my interaction with nurses.
>
> I have a clear understanding (having been a nurse) of what nurses can and cannot do. So when someone tells me I can't do something or no I didn't, I have a very clear idea in my mind if they can or can't. I know the positive things nurses can offer.
>
> Only thing I can say is I feel more empathy in the work that nurses do because I've been there and I know what they have to do. I know their job is difficult, therefore, if something is done that's done well, I make a comment. Or if something is not done, I understand and I make a comment to that effect. So I'm more tolerant of what they have to go through. At the same time when I see things they are not doing that they should, I get very impatient. I have high expectations. The only way that nurses are going to uplift their status as nurses is to uphold professionalism. They need to teach this to themselves.
>
> I do not expect things of nurses that are unreasonable, which a lot of M.D.s do. This is because they don't have a lot of knowledge about how nursing works on a hospital floor.

A female physician admitted initial ambivalence about divulging her past profession.

> When I began as an intern I was quite uncomfortable discussing that I had been a nurse. In fact I rarely brought it up and was uncomfortable when it was brought up. Now three years later, it makes no difference to me. I readily discuss it because I'm more sure of myself in my new role as an M.D.

Female physicians saw varying gradations of rapport between nurses and M.D.s who were former nurses.

> One thing I've noticed is that those female M.D.s who immediately get along with the nursing staff and never have anything but respect, are the female M.D.s who were nurses first. This is my personal experience, but I see it all the time. I'm not sure why, but it has been so obvious to me that I think about this a great deal. Only thing I can think of is that they are skilled from the beginning in making the nurse's job as uncomplicated as possible, because they know how to write an order so it's understood. They know how much time certain procedures are going to take so they don't overload accidently. They know whether pharmacy stocks a certain medicine, or if the nurse is going to have to walk down the hall for it. Little things like this make working with nurses go more smoothly. There is a more instant rapport. Other female M.D.s have to learn this in every rotation.
>
> The worst female M.D./nurse relationship that I've ever seen was between a female M.D. who had been a nurse and went to medical school. She expected so much.
>
> I know two M.D.s who were nurses before. They are more curt with the nursing staff; a lot more demanding to nurses than me. They want to be called "Doctor." They tell me they deserve it because they worked very hard to get there. Most other female M.D.s are not like this.
>
> It may very well be that the female M.D. who has been a nurse is carrying the notion of bettering herself. Now that she's achieved this "higher status," she's hostile to those who didn't.

The Nurses Discussion of Themselves

Nurses recognized the low esteem level of their profession, which was reinforced even at the educational level.

In my nurse's training, the instructors were always battering the students. I've never seen a more defeated group than nursing students. And conversely, I've never seen a more inflated population than medical students. There is something in the esteem building of the professional schools that is very different. In medical school, one is chosen and screened from many and told you are really the "cat's meow" and lucky to be here. In nursing school, I was told the way we need to see ourselves is as really "flexible" with what was going on. Our key thing to be was "flexible." And at my nursing school, they thought they were really progressive. I think also that nursing does attract some troubled people. Nurses do undermine each other. There is competition in nursing on a very peaked pyramid. Very little room at the top. I know about the talk that "if you are smart, why don't you become an M.D." Well the only validity in that is financial. Also I see ambivalence about women having success and I think that seeing a female M.D. ignites that ambivalence in nurses. It does for me. I do feel successful being a nurse. I have had a good career but there is something about the esteem of the profession. In my last job, I had topped out and I had to change jobs to get the potential for more money. Only as a director of nursing can I hope to break $40,000. As a supervisor, I was making in the $20's.

Nurses are too willing to criticize each other; always dragging each other down. All M.D.s do this less. Nurses should learn from this. M.D.s are not willing to criticize other M.D.s to nurses.

I think it's a positive juncture for women to be in medicine. I just hope nurses will pick up its esteem level. A lot of nurses are just clock punchers.

Most nurses are caretakers or rescuers, with many crossing an unhealthy boundary. Many are divorced. There is not enough assertiveness.

I have seen many nurses marry blue-collar men. I've noticed that these nurses don't see nursing as a career. They stay in staff positions and don't go up the ladder. They work part time. They see nursing only as a job.

I think that most nurses haven't delved deeply into their interactions and feelings about female M.D.s.

Nurses reacted to female physicians' pity of nursing by defending their profession.

> Pity of nurses by female M.D.s? Actually I turn it around. I pity female M.D.s. No way would I give all that time. I feel sorry for doctors. Look at the hours they put in and the demands on their time. Unless nurses work with residents, they don't have the knowledge of what doctors have to go through. They have terrible call schedules. What do you do if you have children?
>
> A lot of what doctors pity nurses for can be changed, like the money.

Nurses behaviors toward physicians correlated to their own job satisfaction.

> I see a lot of animosity from nurses toward M.D.s (male or female), especially if the nurse feels dead-ended.

Nurses recognized their emerging professional autonomy and its potential to cause negative reactions among physicians.

> Nursing is changing too. We no longer want to be the "handmaiden" profession.
>
> New nurses are taught to be assertive, and express themselves. They do diagnostic work and do look at the total picture of the patient (laboratory, x-rays, history, etc.), so when an M.D. comes on the floor, the nurse is no longer just the "handmaiden." She's got the ability now, and a lot of M.D.s don't like that.

The nurses noticed three things about female physicians who had previously been nurses: how they reacted to male M.D.s, how they related to nurses, and how nurses related to them.

> One female who was an R.N. first was much more aggressive with male M.D.s.
>
> Female M.D.s who have been nurses ahead of time are tops. They are the best. They are both a nurse (so look at things nurses would look at) as well as an M.D. They tend to be more patient oriented

than just a normal M.D. with no nursing background. They will listen to nurses more because they know what the nurses want to know. They are more compassionate.

One female M.D. who's now in the nursery was a nurse. The nurses' attitude is, "Well she should know how hard it is, she was a nurse before." I guess if you go to medical school you forget what it was like. This M.D. does have a tendency to believe that because she is no longer a nurse and has attained the personal status, "the ultimate," that she has the right to the attitude of well, "I'm the doctor, now you will do this." It is like once some have attained the status, they do a role reversal. Nurses perceived this about this one and talked about her all the time. But they still called her by her first name.

I still don't see M.D.s in general really recognizing nursing as a profession. If you see an older female M.D. intern and if you ask her what she did before, all but former nurses are very honest. Previous nurses seem to ask you why you are asking them. They are instantly defensive. A lot won't even admit they were nurses. There was one who didn't want to be identified as a nurse because, in her past experiences, when nurses found out she was a nurse, they expected her to do nursing. And the M.D.s that she was training with looked down on her (in her opinion).

Actually one M.D. slipped and mentioned she was a nurse and was embarrassed and mad at herself for saying it. She was really playing the M.D. role. The nurses didn't like this and treated her bad about it. She humbled. She got calm and polite, and got more miles out of people. Actually an overcompensatory thing where she felt she had to act this way; seeing this present role that she was unfamiliar with and for which she experienced from a different perspective at one point. She had been the nurse receiving the loud screams, and the chart throwing, and the demands. Now she thought she had to play this role. I've always admired (even kind of envy) nurses who have become M.D.s.

Summary

Female physicians acknowledged the contributions of nurses to health care and in their own personal experiences. They recognized that nurses held vantage points in their spatial proximity to and time with the patient. This, coupled with their unique education, provided valuable input for decision-making in patient care.

But, in addition, female M.D.s observed the frustration of nurses stemming from their lack of professional satisfaction. Some physicians saw the nursing profession as characterized by conditions deemed repressive to women, such as following orders, showing respect for authority, being passive, and having very limited opportunity for advancement. They felt that much of this was perpetuated by the hospital system. This is reflected in disappointment of various working conditions: conditions of overwork, underpay, peaked pyramids for advancement, and by a system of nursing care delivery which exemplified task rather than motivating relational assignments. In the face of this adversity, physicians observed the replacement of nurturance and other important human qualities with frustration and apathy. One female physician, in applying Maslow, felt that nursing could not hope to actualize itself as a profession when working conditions perpetuated a philosophy of just making it through the day. Female physicians reacted to this in varying ways. Some felt empathy or pity for nurses, others believed they supported the nursing profession, while others encouraged capable nurses to get out of the profession (which in fact 11 percent of the M.D.s interviewed had already done).

Nurses talked openly of their own low professional esteem and their desires to see nursing progress to a more respected profession. They felt that the female M.D. could indeed precipitate a clarification of values in nursing, helping them to realize their ambitions for personal fulfillment and more equitable compensation.

CHAPTER 11

VARIABLES

The nature of this research was to solicit perceptions of human behaviors in a specific transaction process. What has surfaced is a sense of the trends perceived by the fifty women who were interviewed. However, as with all qualitative research of this dimension, variables were present. For instance, variables such as the age of the physician or the specialty of the physician were brought up over and over again by women in both medicine and nursing. Other variables were idiosyncratic, albeit nonetheless worth inclusion.

The following variables are included in this chapter:

Individual Personalities;

Age of the Nurse;

Age of the Female M.D.;

Age of the Male M.D.;

Rank of the M.D.;

Level of Competence;

Experience;

Specialty;

Time (Amount and Type of);

Race;

Genderless Decisions;

Type of Hospital; and

Length of the Relationship.

What Female Physicians Saw as Variables

Female physicians saw personality types and differences as a major variable.

> The teaching-learning transaction is more personality related than gender related. An M.D. involved in the care of the patient should involve the nurse's opinions. The nurse spends more time with patient. An M.D. breezes in and doesn't have the time that the nurse has. These aspects, medical, social, etc., are crucial. A good M.D. will value the input of the nurse taking care of the patient. If two professionals are dealing with each other at that level, with some sort of respect and empathy toward the patient, then there will not be a problem. Now a male M.D. whose ego needs to be lorded over someone, or the female who is insecure is not going to get along with that nurse.
>
> If you have got an M.D. (male or female) who is very standoffish, and doesn't want to react to a patient, let alone a nurse, you are never going to have the two working together. They don't work against each other, but not much is going on between them either. They are two strangers approaching the same patient. Whereas if you feel they (nurses) are helping you, you have two people in colleagueship.
>
> The quality of the teaching-learning transaction at the bedside depends on the individual. If they're threatened, there is less interaction. If suggestions are taken positively, good feelings result. If there are put-downs, there is less talking.
>
> The teaching and learning transaction also depends on the person. If they are real sensitive, they will talk more. It's not just all male or female.
>
> The bottom line--It depends on the nurse and the female M.D.

They also discussed the age of nurses as a variable. Opinions were mixed and reflected many differences.

The teaching-learning transaction can be an age related phenomenon. I find the older nurses are more friendly towards women, more motherly. The younger paid less attention to us and more to the men. They were "looking."

Nurses here are older, so they just respond to you as a doctor. They are more like a mother figure. They give you advice and watch over you, and do the same to men. This is materialistic.

The older nurses are used to men telling them what to do. They accept this, and even enjoy it. They don't enjoy it with a woman.

Some older E.R. nurses antagonized the female M.D.s badly, to the point where they didn't want to work there. There were lots of meetings with nursing supervisors to, "Tell them to lay off."

The older nurses are used to the same doctors, so they question the newer doctors. We have to substaniate why we are doing a certain thing or order. I find myself even quoting articles.

Most of nurses I've had trouble with were older. They are more condescending. They let you know that they've had more experience. I don't know if they do same for males. Some older nurses do say, "Go for it, we are proud." I've never had trouble with nurses my age.

Older nurses are less tolerant because they have that "old slave mentality." Over the years, they have been bred into believing that the male M.D. is "God." Very difficult to consider a woman as "God." Therefore old female nurses often religated us to the same position as a new nurse or a social worker. Some are proud.

The older nurses have been around here for so long that I think they get tired of a new crop of doctors every year. And every year they see more and more women. One nurse said the only reason she went into nursing was to marry a doctor, yet now she sees all these women M.D.s and what is she supposed to do.

The older nurses feel free to go after anybody, regardless of sex. They are equally obnoxious to younger men and women, but very careful with older male attendings.

With older nurses, if a male says something, especially an older M.D., no questions are asked. With the younger it's different. They don't necessarily jump when they speak.

The older nurse treats young female and male M.D.s equal, which is sometimes equally as bad.

Female physicians encountered various behavioral characteristics in older female M.D.s, ranging from obsequiousness to hostility.

> I've seen older M.D.s act like "supermoms." While making rounds, they call home to see if their kids are safe. They treated nurses in a "tiptoeing" fashion: "Would you please...If it's not too much trouble...When you find the time." They were real anxious to please the nurses and some nurses contributed to this.
>
> The older female M.D.s do exhibit horizontal hostility. They are much more "macho" because of the hard times they had to go through in school. You see this less now.

Female M.D.s discussed the age of the male physician as a variable in the transaction.

> One does see a difference between younger and older male M.D.s The older are the traditional type. The younger ones don't see the nurses as people who just take orders. They know that the nurses know the patients better than they do, because they are not there all the time.
>
> The younger M.D. has been exposed to women's liberation. But that's not to say they can't certainly be pulled into the older mentoring, in which case, they'll perpetuate the old ways.
>
> Younger male M.D. and older? Oh, definitely a difference. There's a new generation of male doctors. They are much more sensitive, more caring. And overall, they are much more patient oriented than what I have seen in the older doctors. Also they are more personable. Even now in medical school, they tell us to maintain clear cut boundaries between the patient and M.D. I think a lot of this is being lost along the way because the move is to see your patient as a person and to interact with that patient. And the younger do this. They are sensitive and open.
>
> Older male M.D.s tend to have a more traditional view of women. A sort of, "Hey honey--How are you doing today" stuff. More of a patronizing type of relationship.

They also saw that the rank of a physician affected the transaction process. (The hierarchy for doctors begins with a medical student,

then progresses to intern, resident, attending or private practitioner, or, in teaching hospitals, to a chief of department, who in many cases is highly credentialed.)

> How nurses view you also depends on your standing (rank). This makes a difference, and it's harder to estimate gender differences. My boss is a man and older. Nurses do react differently to him than me. But I'm younger and new, so I don't know if it's also because I'm a woman.
>
> I think you do see more helping, etc. at the resident level, where making the nurse your friend is a lot more critical then when you get higher up. As a resident, you have a lot more to gain by making friends with the nurses. So you see a lot of that. Interns and residents make an effort to get the nurses on their side.

One female physician felt that level of competence was a significant contributing factor in quality teaching-learning transactions.

> The more competent people are, the less difference any of this makes. If you have good nurses and good M.D.s, the gender gets to be less important. It just doesn't matter because of their level of communication. So it doesn't matter who is male and who is female.

Female M.D.s considered professional experience another variable.

> The utilization of nurse knowledge depends on the doctor. The more experienced M.D. generally seeks and uses more nurse information. It is not necessarily gender, especially as doctors know particular nurses.

They also felt that the specialty of the physicians (both male and female) was significant in the teaching-learning transaction.

Male pediatricians tend to be less authoritarian than men in other specialties. In pediatrics, you can't put on airs when a eight year old patient looks up and says, "You have a 'booger' in your nose."

The physicians are more concerned about the social problems of the patient on internal medicine service than surgery.

In pediatrics nurses and M.D.s work very closely. There are many women in pediatrics. Things go smoothly. Maybe the specialty affects how women get along. In pediatrics, nurses are used to a lot of women, and there is less tension. Children may be sick but the whole atmosphere is a much more nurturing one. And men in pediatrics aren't usually super aggressive or pushy people. I see this more so with men in internal medicine.

My area is obstetrics and gynecology (Ob-G) and women who go into Ob-G like women, or they wouldn't have gone into it. In regard to men in Ob-G, I think some are in this specialty because they like women and some because they hate them. But in general, a woman goes into Ob-G because you feel you have a lot more to offer other women. There is empathy, less unnecessary ordering of tests, and a "keep it simple" attitude.

The male surgeons are "hyper" and take nothing from nobody. They are male jerks.

Different specialties are different. Surgeons, for example, are very hostile to women. Pediatricians, on the other side, are very friendly. Internal medicine is in the middle.

My colleagues seem interested in the psychosocial aspects of care, but I'm in primary care and general medicine so psychosocial plays an important role in patient management, especially in dealing in a clinic situation. The men I talk to are tuned into this. They know that the psychosocial aspects of patients influence their health.

Interviewers considered time a variable as it related to the busyness or tenseness of a situation. In this case, factors such as gender or rank were minimally influential in the transactions.

In a tense situation, it's unbelievable how beautifully people can function as a team. It doesn't matter who is doing what job.

When people aren't real busy, they can sit around and be "catty." But in a busy situation, things are different. It's more honest, friendlier, people are in touch with the situation, and the

> patient. "We are all here because something bad is happening." There is no time for this other stuff. So people get right down to the most important things, and people cut the "bullshit." Time gives us all the ability to show our differences, and to sit around and grump about them.

Female physicians also felt that demanding schedules of a residency program were an important time variable. In this milieu, priorities had to be established that often placed nurturing characteristics low on the continuum.

> I find many of our residents are hesitant to look at psychosocial issues. This includes men and women. I certainly am interested in this, and I insist that the residents look at this. However, this is where I meet some resistance. Residents are so caught up with the pressures of time: pressures of I.V.s, respirators, and get the orders written. The psychosocial tends to be pushed aside because this hospital has a very demanding residency. If I make a general assessment and go through the list of all my residents, the female would be more sympathetic to psychosocial sorts of things. It might not be as striking though at the residency level as at the attending level.

Interviewees found race to be another variable. Eight of the twenty-seven female physicians interviewed were black. When negative transactions occurred between them and nurses, these physicians felt that their race was a significant influence.

> There are racist attitudes more than sexist. This is very noticeable to me and other M.D.s. I don't think it's woman to woman.
>
> Whenever I have a problem with anyone, before I think it's a gender conflict, I think, "Is it because I'm black?"

One female physician felt that many decisions relating to patient care were performed by rote. Certain questions had certain answers, and these were not influenced by gender variables.

> A lot of things are genderless, e.g. "Can Mrs. Jones get out of bed?" It's yes or no. A genderless decision.

Physicians felt that whether the hospital was a teaching or a private community hospital was a variable. For instance, in one large inner city teaching hospital, female physicians expressed that there were a sufficient number of negative transactions with nurses, but they were quick to add that understaffing, overwork and less than desirable working conditions influenced this. They also observed that younger M.D.s and the lower ranked M.D.s were mainly in teaching hospitals, while physicians of higher rank and age were more apt to be practicing in community hospitals.

> There is a world of difference between a teaching and a community hospital. In the later there are many less negative transactions. Most nurses in community hospitals, if they are going to have negative behavior, will do it covertly. In teaching hospitals, I mean there is absolutely no respect for doctors at all, and certainly female M.D.s the least. However, in teaching hospitals nurses are likewise really abused by doctors. I think that after being in medical school and really feeling like the underdog (oppressed), then you are all of a sudden the intern, and you feel like hot stuff. So they order people around and try to puff themselves up by doing this. I see female M.D.s doing less of this because they are closer to being there themselves. But I think that the anger that this instills in nurses is easier taken out on the female M.D. than the male M.D. Nurses in teaching hospitals grow to expect M.D.s to have disrespectful behavior toward them so they operate on this expectation. And vice versa with physicians.

What Nurses Saw As Variables

Similarly to female physicians, nurses thought that the specialty of the physician could and did influence teaching-learning transactions. Two specialties that nurses discussed the most were obstetrics and gynecology and pediatrics. In obstetrics and gynecology, female physicians received exceptionally high marks from the nurses.

> In pediatrics, I feel there is more of an emotional attachment with the patient by the male M.D.s. In other specialties, I only feel this with the females.
>
> Psychiatrists are different from other specialties because they are oriented to emotional and psychosocial aspects. They market themselves as approachable people.
>
> Dermatology specialists are more even tempered, but there is less stress than other specialties. It's 8-5 with no or little emergency call. It's a relaxed atmosphere with less pressure.
>
> A lot depends on specialty with men. Pediatrics is the lowest paid with the most call. So a certain individual who likes kids is drawn. It's not like radiology with it's big money, regular hours, and minimal patient contact. Pediatricians have a greater sensitivity.
>
> I feel that in initial communications with an M.D. (male or female) that they both listen to you with the same attention. But their response a lot of times differs. This depends on their character maybe as much as sexually (at least in some specialties). In pediatrics, men are drawn to it because of their sensitivity.

The following quotations reflect the positive attitudes of nurses toward women in the specialty of obstetrics and gynecology.

> The female M.D.s in Ob-G are so good, I would let them deliver any babies I ever had. They are down to earth with patient, and not stuffy. They gave a lot of respect to patients, even the young and uneducated. I just think that they are more sensitive. I'm not saying that men are no good; just that women are exceptional.

I see female M.D.s in Ob-G as distinctly positive.

In Ob-G, female M.D.s do have more compassion for female patients and more consideration for teaching and explaining, both to the patient and to the nurses. Because it's a physical area that the female M.D. can relate to herself (child birth, female problems). In other areas of medicine, things are more equal between male and female.

In Ob-G, I think male M.D.s are hard put to believe that women are having menstrual pain or cramps, even though much scientific work has been done. In the back of the mind of a male M.D., they tend to think it's mostly emotional, that females are more prone to give into stress and feel symptoms more severely. Female M.D.s have more empathy.

In Ob-G, the female M.D.s are really unique, especially as they have children. And the female M.D.s will say they are a better M.D. because they have experienced the whole level of childbirth and raising children. They can relate to pregnancy, the aches and pains of pregnancy, and the hormonal changes. They know scientifically and emotionally so they can sit down with patient and relate. It's hard for male M.D.s to relate to aches and pains. They tend to say it'll go away, or give some scientific reason why you are having something like low back pain. But that's it. They are not nearly as empathetic.

Nurses also saw female physicians in certain specialties that allowed them to combine career and family.

I see very few female M.D.s in private hospitals. Women are not as often in private practice. They become attendings in teaching centers. I've seen an increase of women in dermatology, pathology, and radiology residencies.

Dermatology fellowships are quickly approaching 50 percent women. When I've asked them why, they feel they can have family and career.

In some areas, nurses worked consistently with the same small group of doctors. Therefore, how well people were known became a variable.

In dermatology, we see the same people daily. As we develop relationships with these people, gender is less a factor.

Nurses considered competence a variable.

Now that people know me and my competence, there are less games.

If an M.D. respects a nurse for what she knows and can convey that (more than listen and then ignor), the transaction is good.

If incompetent, whether female or male, I lose respect.

I really get bothered if I don't see a patient being cared for properly. I will speak out if I see this...to doctors, nurses, or others.

If a male or female M.D. are not good, you are going to question. This has nothing to do with gender. Competence is the most important factor.

If I was really angry over a patient care issue, I think I would take either a male or a female to task on it. If it was a mute issue, I understand how this could be different.

In defense of men, when it got down to the actual competent medical care of the patient, the team aspect there. In an intellectual concept of the care of the patient, the teamness was there with men. Most men would ask for our feedback or let us know if we had a good idea.

For nurses, individual personalities of both male and female physicians had to be considered.

Women, because of their basic nature, have more of a tendency to express their compassion. But I have seen males who are compassionate and concerned with patients. They are just as capable. It's hard to generalize considering the differing personalities.

The teaching-learning transaction depends on how receptive both sides are. It's a lot personality. Those that are open minded and relaxed, versus those that cause friction and have unresolved conflicts.

Nurses considered the busyness or tenseness of a unit or situation as a time variable.

> This is what is good about emergencies. Everybody is equal and working together. We become one. No one is into social stigmas of high and low roles. All function toward common goal of helping the patient. Codes (cardiac or respiratory arrests) break status down. Only when things are stable do people look in the mirror to say, "Oh- I've got an M.D. behind my name." When there is time, this is when people get carried away with doctor/nurse stuff. A code breaks this right down. Everyone's human and equal.
>
> Gender is not a factor if I, as a nurse, am competent and respected, particularly in an area like an ICU. There is no time for these issues. Issues that are brought up are acute issues. We all bring up problems, we all work to solve. I never felt gender was a factor.

Nurses also noted differences in the teaching-learning transactions in private and teaching hospitals.

> In teaching hospitals the team work is much more of a focus than other places.
>
> If I believe in what I'm doing, then I say it. I don't mince words to make it seem like it's their thought. In private hospitals and with attendings, however I would use the words, "It appears to be." But here I'm in a specialized area with new doctors who have just closed the books and now are coming into clinical practice. I tell them what they need to be doing.
>
> The "I-think-rather-than-it-appears-to-be" attitude is absolutely different in teaching hospitals versus private hospitals. Here (at this private hospital) I can't say Mr. so-and-so has this. Instead I ask male M.D. to please check him because I think Mr. so-and-so might have this. With women, it's different. There is not this game. Also different with newer doctors.
>
> I love the environment of teaching hospitals, probably because nurses have more power.
>
> Nurses also, at this public hospital, have more nursing support. A nurse won't get fired if she calls a doctor down. At a private hospital, this is a real possibility. Doctors in the private sector are catered to more.

I do think M.D.s can be abused at this public hospital also. They have to transport their patients all over the hospital to x-ray etc. I don't think this is right. Maybe they get bitter about this. This is very menial trash.

I see vast differences between a private and big public hospital. The private is very traditional and relationships are different. In this public hospital, I have a lot of autonomy, responsibility, and can make decisions, and generally they are listened to. I don't see this as identifiably at a private hospital. I hate to be mean about it, because I don't have M.D./nurse hang-ups, but it's still a "God" role at some of these private hospitals. The M.D.s have so much power. Like at this one private hospital, you have to have a doctor's order to do diabetes teaching. As a diabetic educator, I know how important it is for nurses to assess teaching needs. But at this other hospital, you must have an order from an M.D. and then you must know what he "likes" for his patients to learn. Some of the older ones don't like this or that; they are even doing things medically behind the times. Here (public hospital) I don't need an M.D. order. Can you imagine having to adjust your teaching on what a physician doesn't know? The patient is for sure not getting as much good information as he needs.

It's a lot different in private hospitals. In a training hospital, a lot more communication is going on. In private hospitals, the nurse always has to prove herself.

Nurses saw differences in professional autonomy and assertiveness as being related to age. Nurses with experience and knowledge sometimes felt hostile toward physicians whose salaries were so much greater than their own.

Upbringing has a lot to do with way we interact with male or female M.D.s. I was taught as a child that my father was the boss and this is how I have always viewed men. My psychological upbringing. This has to carry over. Younger nurses in 20's were not raised this way. They are taught that they can question and talk back. They don't have that same respect for male or female M.D.s. We will probably see this change continue. In my era, we never called an M.D. to suggest something. Now they will. In my era, you told the doctor the situation and let him make up his mind, or you softly manipulated him.

If nurse has been in specialty area for years, they know their stuff inside and out. Then this new person comes. These nurses are looking for respect. They see that they know more, and yet

> they know that in a few years this intern will be making 1000's of dollars more.

Nurses mentioned the rank of the M.D. as important in setting the climate for transactions. The power of the nurse was demonstrated most often when negative transactions with interns had occurred.

> The interns have such fragile egos. They are so insecure about their knowledge base that they try to compensate by "jumping the gun", i.e. knowing all about their patients so you can't tell them anything. This is one segment of the M.D. population where nurses can use power. The interns get kicked around a lot. Often see the changes; some 2nd or 3rd year residents listen a lot. Others realize they are on their way out and say, "Forget it- what I say goes." Some probably go on to be really obnoxious M.D.s, who hate nurses. And I think we have contributed to this.
>
> I react differently to interns than to attending M.D.s. Sometimes, with an attending, you really care and feel something should be done for the patient, yet you know you've got to cross this ego barrier with this doctor. To get what you need for this patient. I will sometimes say, "I saw this and I thought you would like me to do this." Or "Maybe you'd like the opportunity to order this." Give them the credit. I don't care who gets the credit if the patient benefits. I compromise. With an intern, I'm straight, and if I don't like his/her response, I go to the resident, etc.
>
> One night on 11-7, an intern admitted a patient and then left for a few minutes. In the meantime, I started doing the data base. I later saw him again, but didn't think anything of it. Next thing I know, he was calling the nursing supervisor and complaining loudly that I wouldn't let him examine his patient! I had no idea! He didn't say, "Excuse me, may I talk to the patient," or anything. Needless to say this was not forgotten by any of the nursing staff. What usually happens is he gets worse and so do the nurses.
>
> I see a lot of book knowledge with residents but very little practical. They lean on us to fill that part in.

Nurses wanted recognition for their contributions to the care of the patient and to the education of the new physician.

ICU nurses do a lot of teaching for new M.D.s right out of medical school. So if this relationship got off to a good start, usually it stayed good. This happened with both men and women. In this situation, the M.D. really needs the nurse. She's a big teacher. For example, in a complicated procedure, the nurse may say, "I not supposed to do it but I can tell you how to do it." Nurses in ICU for many years show equal impatience to males and females. They know ICU nursing inside and out, regarding procedures, care, and evaluation. Now if somebody fresh out of medical school didn't accept her opinion, this can start a very bad relationship, which will continue for the length of that M.D.'s residency. This happens in medical and surgical areas also. Nurses get angry if they suggest something, are not listened to and then, what they thought would happen, did. With a new M.D. (fresh intern), nurses will also try to prove what they know. Same with any new M.D.s on the unit even if they are skilled intensivists. Nurses want to show their knowledge.

Nurses saw differences between the older, more confident female physician and the insecure female physician in training.

There is a difference when dealing with the female housestaff and female attendings. Attendings tend not to be threatened and tend to be teachers. The female housestaff can get into, "I have to prove myself--I'm so threatened. I'm going to attack first and ask questions later." Or they are normal human women but they overly act like professionals, or they are so distracted by fear that they don't function at all.

It is different dealing with an attending versus housestaff. A phenomenal difference in how women M.D. and nurse relationships change here. There is more humor in the older, more secure ones on both sides. There is laughing and joking, and it's not sexual of course. Friendships develop with these women.

The older female M.D. is different. I always looked at them in awe, for what they've done. There is a very mothering, almost dependent type of nurturance from both sides. Like a woman has to be better than good in a man's world.

It depends to a large degree on past experience. I have seen a large amount of women who have gone to medical school, who previously had other careers. They are not coming in anxious. It also depends on other constraints at home; if they have a family and children, they often don't relate as well to the younger nurses who are single, or who they perceive as having less life experience.

Overwhelmingly, nurses saw the age of the male physician as significant in the transaction; They reacted more positively towards those who were younger.

> The younger male M.D.s, just coming out of school, are much more sensitive and easier to work with than older men. They can come close in this regard to the female M.D. Age may be, in some cases, more the factor, or at least equal, to gender.
>
> I'm thrilled when we get a new M.D. who is well trained, and knows new techniques. Older ones have to be talked through it, because they haven't done it for ten years. You get the book out and read the procedure to them, and hold your breath!
>
> The age of the doctor makes a big difference. Back in 1968, the male M.D. was the law, he was "God" and you showed respect, even to point of standing up when he entered nurses' station. Don't see this today. It's good that you don't because this prevented communications. What we see now is better communications.
>
> The female M.D.s and the younger male M.D.s are tapping the opinion of the nurse more. They listen to the nurse more. They treat us with more respect.
>
> The younger male M.D.s are different from older...but still different from the women.
>
> I don't think the older men were given any training in the psychosocial needs of the patient. It's like, "I'm here. I'm the doctor. This is the illness and this is what we do to get it better. If you (the patient) don't like it, go find another M.D." I've heard this many times. I used to think nobody cared. For a while I thought, all these people coming out of medical school, and nobody cares. I thought they were more interested in going out and making money. The younger group (the ones I've seen in the last few years) are a real treat to work with.
>
> I see male M.D.s changing, especially the younger ones coming up.
>
> I do think that younger men are better. I have worked with men who are geared to the whole of the patient and they listen to nurses or the family. I don't think all male M.D.s are the stereotypical ones. Their relationships with women are different. Maybe this compassion is becoming more instinctual for them. I hope.

CHAPTER 12

INTERPRETATION, CONCLUSION, AND RECOMMENDATIONS

Interpretation of Results

Clearly social and environmental factors did affect teaching-learning transactions between women physicians and women nurses. This effect was generally positive as evidenced in participant satisfaction and in improved aspects of patient care. Hence, the results were perceived in both the processes and the outcomes of the transaction.

Positive teaching-learning transactions began with the establishment of a climate characterized by increased approachability and decreased social distance and professional authority, which in turn facilitated a nurturing environment. Within this nurturing environment was an enhanced reward structure symbolized by recognition of work and role, exchange of compliments, solicitation of opinions, and listening. Likewise, there was a shared commitment to helping each other. In essence, one positive characteristic produced others.

Such a milieu optimized individual and professional motivation. A comfortable climate opened doors, encouraging each participant to

contribute her expertise to the ongoing success of these processes, thereby enhancing personal rewards. Women physicians and nurses shared each others' scientific data bases, fostering unity of their respective professions and creating colleagueship.

The ultimate benefit of a positive informal teaching-learning transaction was to the patient. Basically, the kind of climate generated between women physicians and nurses was extended to patients, allowing them to more fully participate in this process. This is especially evident beyond the clinical prescriptive component, in the realm of psychosocial aspects and discharge planning. Here participants felt that their sensitivity to these issues enhanced the humanistic element of patient care by integrating the disease with the person, and communicating this verbally and tactilely. There was greater attention to patient comfort, concern in diagnosing and resolving potential psychosocial problems, and personal involvement in post-hospitalization planning and patient education. Participants felt that this led to increased patient compliance, improved care, and better resolution of the consequences of illness on a person's life style.

Interviewees perceived that the enhanced quality of teaching-learning transactions was rooted in the similar socialization background of women, with a resultant integration of this social conditioning with professionalism. They focused on two areas. The first area was that of feminine characteristics which emerged from common patterns of upbringing. The foremost of these, nurturance, was recognized as a strength and desired attribute, particularly as applied to health care. The shared capacities of female physicians and nurses to nurture produced remarkable rapport. A similarly powerful emotional

and biological binder was motherhood. They felt that these connections influenced their views on life, illness, and death, and their capacities to provide care while supporting the process. Again, out of these shared traits surfaced the feeling of a more humanistic approach to patient care.

The second area was that of the repressive aspects of feminine socialization. This became increasingly important as interviewees reviewed their feelings on historically limited and prescribed opportunities for women in our society. The concept of minority, and the factors of discrimination inherent in this status, produced mutual empathy, a strong sense of being female, a sometimes joint recognition of male oppression, and a bond in the teaching-learning transaction. This was further exemplified by reciprocal support, recognition, encouragement, desired deviations from traditional doctor-nurse relations, role modeling, mentoring, and pride.

The gender of the participants affected the transaction in other ways. For instance, between women there was less humor and more projected need to apologize for real or imagined deviations from positive transaction expectations. Women participants, in analyzing humor, saw different amounts, types, and reasons for humor in transactions between men and women and between themselves. In the former transactions, humor was seen as a form of flirtation, attraction, manipulation, or expression of discomfort. Teaching-learning transactions within this framework could have ulterior motives and connotations. In transactions between women, humor was not as prevalent because of the initial comfortableness established, which subsequently reduced the need for manipulative behaviors. Furthermore, flirtation

and attraction were absent between women. (It is not known if any interviewees were lesbian; therefore, the aspect of women's sexual attraction to each other did not emerge.)

The need to apologize also directly related to gender. Women acknowledged that anger or aggressive behaviors were not socially acceptable feminine characteristics; therefore, these behaviors could induce guilt. Beyond this uncomfortableness, they recognized that the perception of these behaviors triggered a hostility in some women which could permanently mar future transactions.

Authority became a complex issue which could, through its reduction in professional relationships, encourage approachability and enhanced transactions. Yet, as other social, environmental, and personality variations juxtaposed with this, authority often emmerged as the impedus to barriers between women physicians and nurses, reducing the transaction quality accordingly.

This was a sensitive area for female physicians. First, they acknowledged that masculinity, authority, and power were strongly correlated in our society, and that, therefore, women were accustomed to having males in authoritative positions. Furthermore, women recognized that their socialization had not always fostered the development of effective leadership qualities and assertion. So women knew that they could not command this style with results equal to men.

Second, women physicians did not necessarily want to perpetuate the traditional pattern of power which expects and receives submission. They sought a practical personal power: that of a convincing force which achieves respect by its very nature. But this often posed a dilemma and caused frustrations. They wanted to reduce the image of

overpowering authority, yet because of their role, they felt the need to retain some authority. How to do this and to what degree were often difficult questions to answer.

The ambivalence of women M.D.s over authority was focused in issues relating to how they should be addressed by the nurses and how much they should reduce social distance. Furthermore, even as some female physicians sought to reduce doctor/nurse barriers by inviting nurses to call them by their first names, they felt that some nurses did this automatically to reduce their status as physicians. Hence, the complexities were apparent as behaviors manifested between two individuals generated diverse interpretations and reactions.

Sometimes the positive climate created in their transaction with nurses was related to their perceived lack of authority rather than to feminine bonding. For example, some teaching and learning transpired because female physicians felt their orders did not carry as much credibility as those of their male counterparts. To compensate, they expanded the teaching-learning transaction; it became their form of sexual manipulation. As a last resort, the female physician did evoke the power granted to her by profession. In these cases, the progressive adult education and managerially effective techniques so often seen in a positive transaction between women were sometimes replaced by traditional role authority and reactional behaviors, all capable of provoking dramatic negative effects in future teaching and learning.

Another social factor relating to authority was nursing's progressive liberation and desired autonomy. Nurses viewed traditional male M.D. authority as repressive and controlling. This was vividly seen as nurses felt that the success of a transaction with these M.D.s

relied significantly on a skillful and disguised methodology rather than actual content. This condemnation of traditional power coupled with their decreased ability to be intimidated by women, often precipitated some adverse reactions to female M.D.s. And some hostilities of nurses towards the authority of males and/or M.D.s was substantially bolder when projected on to a woman. This was especially true if they perceived that a female M.D. flaunted this authority over them in a symbolic gesture of gender "one-upmanship." In essence, nurses were extremely sensitive to the way female M.D.s presented themselves and treated nurses.

There were other factors which could regress the established positive transaction. Among these were the education, status, and financial discrepancies between the two professions. While these have always been apparent, there seemed to be more acceptance of these discrepancies between men and women than between women. (Sometimes the degree of positive transaction between women might just depend on the clothes worn by the female M.D.)

Women recognized that they did compete with other women. They compared themselves on everything from attractiveness to body image to intelligence. And sometimes underlying these comparisons was the motive of vying for the sexual and professional attention of men, often at the expense of other women.

The female physician did prompt nurses to examine their personal goals and profession. Nurses recognized lower esteem in their profession and felt that the status and salaries of nursing were not equitable to those of physicians. Seeing feminine contemporaries with all of these desired amenities, at the very least, induced reflection,

which was sometimes exhibited as hostility, or jealousy. This was exacerbated as M.D./nurse levels of job satisfaction became particularly dichotomous.

Perhaps more than anything else, unmet expectations among women were at the core of barriers between women that could result in reduced quality transactions. And women had more than a few expectations for each other. They saw themselves as a minority with all the obligations and struggles that this represented. Subsequently, they expected professionalism, equitable treatment, competence, positive nurturing, esprit de corp, support, and respect. Women were particularly degrading of each other when sexual seductiveness preempted professionalism, or if women emphasized status and role differences.

What they might tolerate from men, such as risque jokes and accentuated status, was not tolerated from women. Furthermore, women were expected to do things that men were not, such as helping in the direct care of the patient. While the latter was viewed as a generally positive aid to communication, the extent of expectations was often perceived as unrealistic. Initially the interactants in the transaction might present themselves as woman to woman. But should this fall short of anticipations, the consequence could be a reestablishment of distinct doctor/nurse role differences, with a reduction in gender linkage and initial transactional gains.

The health care system, specifically the hospital, is important to analyze in the process of interpreting this research. Consistently, the interviewees felt that the system under which they worked had varying effects on the transaction process. This included rather severe

conditions of overwork or underpay, which, in undermining one's motivation, carried over to interpersonal relationships.

It became apparent that individuals working under environmental and personal stresses experienced the erosion of qualities and ideals, like nurturance, that they began with. Reality, for some, was indeed a shock and often left the ambitious and dedicated nurse apathetic. This eroded the teaching-learning transaction as well as the core of their professionalism.

The condition of overwork, particularly in some inner-city hospitals, was extreme. Substantial negative examples of the teaching-learning transaction in these hospitals were perceived to be a result of this factor. Another example where the system is blamed included the process of nursing care delivery. When nurses split patient care functions, such as medications and procedures, there was less individualized care. So the nurses, instead of doing everything for a specialized number of patients, were doing only specific things for a large group. Besides knowing the patients less, their motivation suffered under this regime. In units where there was adequate nursing staff providing total patient care, both female physicians and nurses noticed that their interpersonal dialogues about patients were more significant in quality and quantity.

A final interpretation shows that social and environmental factors produced many positive effects in the teaching-learning transactions between women in medicine and nursing. But sometimes, nestled within these positive processes and outcomes, was the potential for problems. In spite of individual personalities and other variables, there was strong evidence that the past and present ramifications inherent in the

gender of the participant were substantially influential on the degree of effectiveness in these professional interactions.

Conclusions

A mutually satisfying teaching-learning transaction produced positive results. Foremost, it was of benefit to the patient. Second, it enhanced job fulfillment and motivation, particularly for the nurse, and brought out individual capabilities. Third, it increased learning among all participants. Finally, it created better relationships between the participants. Conversely, negative transactions were detrimental to patients, reduced job satisfaction, inhibited individual capabilities, decreased opportunities for learning, and, finally, created interpersonal conflicts between doctors and nurses.

The purpose of this research was to discover and interpret the processes inherent in one particular transaction--the one between women in medicine and women in nursing. It did not attempt to attach any quantitative statistical significance. This was a qualitative study of human behavior in a complex situation within a complex society having a complex history. Hence, it was affected by many variations of experience. Yet, out of these variations emerged trends and similarities provides a basis for analyses. The variations were comprised of idiosyncracies proving to be valuable as insights and, sometimes, as visions.

Social and environmental factors are dynamic and changing. Realistically, then, one can see that this study is defined by the era in which was done. The fact that this particular research project is

already history speaks to this. And, rightfully so, because this research is meant to be a stepping stone in a forward-moving process, a beginning not an end. It provides essential pieces to an already multifaceted issue, an issue that is not and will not become static. Its theories are (as they should be) open to quantitative study.

Assessing the transactions of women among each other often led to making comparisons with men. Many times comments were less than flattering. Negative connotations assigned to transactions with men varied in meaning and severity, and sometimes were not clearly perceived. But this paper's purpose was not the denigration of men. Obviously, a study of women by women will invite some comparative analysis to situations with men. In this case, that analysis was sometimes condemning. Hopefully this will expose barriers, not create them. Once exposed, they can perhaps be dissolved.

The interviews which supplied the data were themselves teaching-learning transactions, for both teaching and learning occurred throughout this process. When one participant group heard comments from another, their reactions, in most cases, caused reflection, not defensiveness. In desiring effective communication participants were willing to think about the issues. One clear and very positive example was the reaction of an obstetrics-gynecology resident in a large teaching hospital. After hearing quotations from nurses espousing their support for women in obstetrics and gynecology, she spontaneously remarked, "That's so nice. I really appreciate that." Her feeling sparked a desire to facilitate the potential of future transactions.

While there are correlations which can be transferred to other groups of women working together, there are some characteristics which

will probably always remain unique to this group. The concepts of homophily and heterophily are easily transferable to women in workplaces of business, law, education and such. Similarly the bonds produced from female socialization or motherhood are probably quite universal, as are problems relating to authority. However, the concept of nurturance as (applied to a sick patient) may have a unique applicability in health-care. Its significance with women in other non-health care professions would make, in this researcher's opinion, a remarkable study.

The teaching-learning transaction is an integral part of the informal educational process among doctors and nurses. Its importance cannot be underestimated in light of the final result--improved health care. Yet, while seemingly simple in definition, the teaching-learning transaction is influenced by many diverse and complex social and environmental factors. Society, the past, the health care system, the status of women, and the individual person all influence the quality of the teaching-learning transaction. Hopefully, the discovery of this information will be used to a positive end in health care. Out of this can emerge the capacity to realize the tremendous potential of the teaching-learning transaction, not only for the people who participate in it, but for the patients who benefit from it.

Recommendations for the Improvement of Practice, Including Strategies for Diffusion, Implementation and Improvement

Six major recommendations have been deduced from this study. All but one focus on the educational process and the development of various related curricula related to the whole or parts of the research. The targeted audiences range from students matriculated in the basic training grounds of academia to seasoned professionals in continuing education programs and journals.

A first recommendation is to present this data, via journals and workshops, to the hospital and nursing administration audience. Many factors inherent in the teaching-learning transaction are dependent on the system by which health care is delivered. For instance, apathy and loss of nurturing characteristics occurred when individuals worked in understaffed and stressful conditions. Likewise, nursing motivation suffered as nurses split patient task assignments instead of delivering a total care approach. This lessened access to patient information and problem-solving opportunities. The consequence of sacrificing nurse potential was a diminished knowledge base within the transactional framework.

A second recommendation is to present these data to medical students, particularly women. Through education, the student could recognize the issues related to being a female physician. Topics for this curricula might include outlining relationships, authority, roles, history of the doctor-nurse interactions, female mentoring, and nurturance.

A third recommendation is the promotion of the concepts of bonding and barriers among women. This can be achieved in educational institutions or through continuing education programs. If one wishes to reduce barriers, one must understand the roots of the hostilities that cause them.

Many current behaviors can be traced to the influences of early learning. The characteristics of many women, from obsequiousness, to reactional anger, to preoccupations with achievement, to name a few, can be seen as the results of unresolved conflicts and inadequate self-esteem. Learning about this and sharing observations can do much to help women analyze their behaviors and begin to seek a resolution.

Perhaps the best thing anyone can do to surmount barriers among women is to realize that the greatest liberation is not for women but for individuals. Several issues in this investigation directly or indirectly related to identity, esteem, and self-worth. If people have freedom within themselves, then they have in their possession the most powerful force by which to overcome diversity and prejudice.

A fourth recommendation is to share this information with the National Joint Practice Commission, a collaboration formed by the American Nurses Association and the American Medical Association. The goals of this commission (set up in 1972) are to remove sources of professional differences, to define new roles and relationships, and to recommend changes in professional education to support new roles. This research is relevant to these goals; therefore, through this commission programs could be initiated at local, state, and even national levels. These programs could concentrate on the strengths, problems, and

capacities of the teaching-learning transaction, not only between women, but between men and women as well.

A fifth recommendation is the exposure of both medicine and nursing curricula to management, educational, and motivational theories. Since teaching-learning transactions are based on people's ability to work together, knowledge of these theories could enhance the potential strength of this interpersonal relations process. The human component becomes particularly important as health care becomes a maze of technological advancements. The motivation of individuals to act as advocates on behalf of the patient is related to their abilities to establish ongoing positive transactions. Therefore, a core knowledge of relevant theories of human motivational behaviors could enhance this endeavor.

The sixth and final recommendation is to apply quantitative tests of significance to the developed hypotheses. This study is open to further exploration wherein the ideas presented can be critically subjected to further substantiation or rejection. This study may perhaps become part of a continuum. It has furnished some answers, but it has provided a stage for many more questions.

Strategies for Diffusion, Implementation, and Improvement

The results of this Major Applied Research Project focused on the exploration and discovery of barriers and facilitation of informal teaching-learning transactions between women in two professions. Through this discovery, one can begin to understand the dynamics of

dealing with this process. The potential application of this understanding will be disseminated on many education levels. This includes the basic training grounds of medical and nursing schools, joint professional practice committees at local and national levels, in hospital educational programs, professional continuing education, and, of course, present and future interpersonal relationships.

Knowledge dissemination and understanding are keys to the potential of this Major Applied Research Project for improving the educational practice as it relates to this particular professional teaching-learning transaction. Through the process of this discovery, one can begin to seek ways to improve and discover potentials. To the extent that bonds can be strengthened and barriers weakened or eliminated, there will be more exchange of information and participation in problem solving processes. This can lead to, relate to, and affect the quality of care given to patients and strengthen the professional capacities of those who deliver that care.

The discoveries in this Major Applied Research Project will be diffused initially through written literature. Publication of findings at a national level and in the professional journals of nursing and medicine (including the women's medical journals such as MEDICA and Women in Medicine) will assure dissemination of knowledge to the reader populations. Furthermore, since results will have applications to the general study of women, it is hoped that this information will be accepted in such publications as those sponsored by the National Women's Studies Association (NWSA).

The goal will be submission of manuscripts soon after the M.A.R.P. completion. Perhaps after manuscript acceptance and publication will

come the offer to do educational workshops on this topic. Such workshops would provide a way to come face-to-face with the women who would want to benefit and learn from this knowledge.

A copy of the M.A.R.P. abstract will be sent to literary sources which publish dissertation and research abstracts. For example, Sigma Theta Tau, the nursing honor society, has an annual publication concerning the research work of nurses around the country. Copies of abstracts will also be mailed to regional schools of nursing, medical schools, and professional associations. These will be accompanied with cover letters offering to share this research with interested faculty, students, and colleagues.

Two local senior level colleges (University of Maryland Eastern Shore and Salisbury State College) will be approached in regard to this researcher's potential participation in women's studies curricula. The University of Maryland Eastern Shore offers no course on women's studies and Salisbury State College offers only one. With such close geographic access to the National Women's Study Association on the University of Maryland College Park campus, it is possible to make available numerous resources to assist in the expansion of programs offered by these institutions, in regular course offerings and in community continuing educations programs.

A final goal of manuscript publication and topic exposure via workshops will be to attract the interest of others who might continue scholarly research in this area. This study may also provide the impetus to seek funding for future efforts. At present this M.A.R.P is the only known research on this specific topic, but perhaps it will provide a motivation in what may be an ongoing process.

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APPENDIX A

SAMPLE INTERVIEW QUESTIONS

1. In regard to patient care, do you feel that the informal professional transactions among women in medicine and nursing are different or the same as among male physicians and nurses?

2. What experiences have you had which make you feel this way?

3. How do you feel being of the same sex affects the nurse-female physician teaching-learning transaction?

4. What do you feel are the most rewarding (e.g. facilitation) aspects of the nurse-female physician transaction?

5. What part does gender contribute to this?

6. What do you feel are the most negative aspects of the (e.g. barriers) nurse-female physician transaction?

7. What part does gender contribute to this?

8. What differences, if any, do you see about the way nurses communicate to female physicians than to male physicians?

9. What factors do you feel contribute to this?

10. How about the way female physicians communicate to nurses compared with male physicians?

11. What factors do you feel contribute to this?

12. What social and environmental factors in our society do you feel have influenced the teaching-learning transaction between women in medicine and nursing?

13. Preliminary introduction to quotes from previous interviews: "I'm going to read to you some quotes said by female M.D.s or nurses and ask you to react to these. Please keep in mind that each quote I read you was said by only one other person."

BIOGRAPHICAL SKETCH

Carolyn B. Stegman received her B.S. degree in Nursing from the University of Miami (Miami, Florida) and her M.S. degree in Community Health Education from Hunter College of the City University of New York (New York, New York).

She has been active in nursing and patient education, and nursing research throughout her career. This experience has included faculty positions, and the coordination of hospital based nursing and patient education programs. Currently she is a consultant in the administration and staff education of primary nursing (a progressive nursing care delivery system).

Ms. Stegman has conducted numerous continuing education seminars throughout the United States on assertiveness, leadership, primary nursing, conflict management, and adult education. In addition she has authored articles on primary nursing. She resides in Princess Anne, Maryland with her husband and son.